Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5:02 Dona1d Hartman April 29 ,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atria Assisted Living Salisbury
Inder 1 Year | If Under 24 Hrs. | Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. Months Days 1₺ M 2□ F Hours August 28,1913 South Dakota Director 008-10-5829 96 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the less call Examiner must be notified at 1 X Yes 2 □ No Director FLPalm Beach Riviera Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1201 Yacht Harbor Drive 33<u>404</u> Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 漢Yes 2 No 1941— If Yes, Give 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify þ Specify: Year or Dates: 1946 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Senior Loan Officer Dept, of Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Jacob Η Hartman Lillian Belle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Hartman- Son 10128 North Avenue West Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ò 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. 5-5-2010 | Hurlock, Maryland Cem. ES 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home 23a. Parti. Enter the disease, or complications that caused the death. shock, or heart failure. List only one gause on each line E. Main St. Salisbury, MD_21804 Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) | /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) s been signed by the s should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has page 2 1 Yes or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \maltese Other (Specify) Asst. Lvg 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 ☐ Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ompletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign MilfordSt. SuitesDYB, Salisbury Mar 31. Date filed (Month 32. Registrar's Signature State MAY 03 Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#12 18 per FH. G904 6730/2010 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** ROBERT Μ. HAMBERG SR. 2 20/0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8941B TOWN CENTER CIRCLE #107 LARGO PRINCE GEORGE'S 8. Date of Birth (Month, Day, FEB • / If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months 1929 1 √2 M 2 □ F SOUTH CAROLINA 249-38-7466 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hyglene.
em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, in "modical Eventh", in "it is not in the property. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty∑Yes 2 ☐ No PRINCE GEORGE'S LARGO 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 8941B TOWN CENTER CIRCLE 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 2 3 10 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ≥ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE **MECHANIC** 18. Mother's Name (First Middle Maiden Surname)
PEARLIE VENDELK SMITH 17. Father's Name (First, Middle, Last) Be WILLIAM H. HAMBERG SR. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and HOPKINS, SOUTH CAROLINA 29061 PAMELA A. HAMBERG/DAUGHTER 22 POWERS COURT item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ± 5 RIVERDALE CREMATORY RIVERDALE, MARYLAND 5/4/2010 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arteriose disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify). the a bed 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes 1 ☐Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this cartiflood director, 25. Was case referred to medical examiner2 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

The law requires that the death certificate be executed

O. Box 68760,

Division of Vital Records,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April HUTSON Doris. 3:37 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth If Under Funeral 9. Birthplace (State or Foreign (Month, Day, Year) an 31, 1946 1 □ M 2 🗓 F Months Days Hours Min De laware Director 221-28-7872 64 Jan Usual Residence of Decedent show 10a. State 10h. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10979 Greensboro Road 21629 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lewis Killen Myrtle R. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Medford Hutson/ 10979 Greensboro Road; husband Denton, Maryland 21629 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hopkins Cemetery 04/30/2010 Felton, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160: Greensboro, MS 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, herniation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 12 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 10 days signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury Subarachnord that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 10 2945 intracranial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 only one

Registrar

29b. Signature and title of certifie

BYAN

APR 27

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOWAK

DHMH 17 Rev 7/2009

22

. Registrar's Signature

29c. License number

S. Greene St., Suite 12-5-D

AU1476435N18873

April 25, 2010

Baltimore, MD 2ROI

	1.	For State Registrar		iai y iai ia i	•	ificate of	Health an <i>Death</i>	IG WE	, ,	eg. No. 2	011	1 155		
	1.	. Decedent's Name (First, Middle, L	Last)						Date of Deat	h 3. Time of I				
an cal		Michael Dean Ho	ollada					A.	Month pril 3		Day Year 8:15			
ner	4a	a. Facility Name (If not institution, g	ive street and number	r)		4b. City, Town,	or Location of D			T	ity of Deat	h		
		24 Chestnut Dr				E1kto				Cec				
	5.		Sex 7. A	ige (In yrs. last b	Yrs	If Under 1 Year Months Days		Vin.	Date of Birth (Month, Day,	Year)	Co	hplace (State or Fo untry)		
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Director	10	De. Street and Number			10f. Zip Code		_	1	0g. Citizen o	f What Co	untry?			
	_	24 Chestnut Dr				2192				United				
Funeral	11	1. Marital Status	t Ever in U.S. ?	13. Wa	as Decedent of Yes, specify Cul	Hispanic Origin oan, Mexican, P	? (Specifi uerto Ric	y Yes or No- an, etc.)		ace - Ame lack, White	rican Indian, e, etc.			
by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	unknown	1[⊒Yes 2M∏No	Specify:			Spec	cify: Wh	ite		
		15. Decedent's	Education			nt's Usual Occu				16b. Kind of	Business/	Industry		
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Be	17	7. Father's Name (First, Middle, La.	st)				18. Mother's	Name (F	irst, Middle, N	Maiden Surna	ame)			
은	-	Floyd Hollada							Unkno					
		9a. Informant's Name/Relationship					t and Number o				ın, State, 2	Zip Code)		
-	Linda Hollada/wife 24 Chestnut Dr., Elkton, MD 21921											Town State		
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 05-08-2010													
	-	4 Donation 5 Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Mary1a 21. Signature of Fooral Service Licensee 22. Name and Address of Facility R.T. Foard & Gee												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20ay 2010 6:35 РМ Ethel May Irwin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing Home Denton Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕸 F (Month, Day, Year) 112 - 24 - 1933 Delaware Days Hours Director 221-20-1091 Aug. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Caroline Ridgely ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 203 Strawberry Court 21660 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Luggage Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford Knight Beatrice Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darry Buckle 234 Slaughter Station Road, Hartly, Delaware 19953 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery May 5,2010 Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
106 W. Sunset Ave., Greensboro, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical npleted filled in by the funeral director, 26. Place of Death (Check only one) 1 Tes 2 No Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 2. Registrar's Sign State

Registrar

MAY 05 2010

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April ZINAT JABBARY 2010 3:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs (Month, Day, ept. 24 1 □ M 2 🕱 F Hours Min. Year) Country) 217-08-3129 Director 89 Iran Usual Residence of Decedent 28a-f shov 10a. State with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11409 Cushman Road 20852 Iran 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Housewife Domestic Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ismail Jabbary Touba Zarrabi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 11409 Cushman Road, North Bethesda, MD 20852 Shahla Sartip/Daugter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 05/027 cemetery, crematory or other place) ò 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park Rockville, Maryland 2010 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service License 101# OH any 11800 New Hampshire Ave, Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\subseteq \) Yes 2 \(\overline{\overl Month Day Veal Pregnant at time of death ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0062435 April 30, 2010

10110 Molecular Drive, Suite#206, Rockville, Maryland 20850

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sayed ElSayyad, M.D.,

03

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#7perFH, 5/3/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EROY DONES 12:55 PM 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HEALTH MONTGOMERY JAIIHERS BURG WILSON CARE Age (In yrs. last birthday)

69 | 10 | Vre

Months Days House Min 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 M 2 □ F Louisiana 434-58-0220 04-03-1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2x No Maryland Montgomery Laytonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21600 Goshen Oaks Road 20882 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes ¾☐ No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Business Owner Management Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnnie Will Jones Pearlie Bickham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Evelyn Jones/Wife 21600 Goshen Oaks Road, Laytonsville, MD 20882 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Remov al from Metropolitan Crematory Alexandria, Virginia 4 □ Donation & □ Other (Specify) 21. Signature of Puneral S 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Pa 11. Enter the di-ease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final week disease or condition resulting in death) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. if yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Dunknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 **N**o 26. Place of Death (Check only one)

Physician /Medical Examiner

physician and s the burial-transit

ettending physician for use as the burial

signed by the e

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page 2 certificate

After this certific funeral director,

after death.

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Certification: To

Medical

Box 68760,

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of Vital Records,

Division or Attending

The law requires that the death certificate be

permit. Pages 1 and 2 & Department of Health ar Important: If Item 27 is any injury or other treuone.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiens. 77 is merked other than "natural", or items 23a or 28a-f show reumate event, the Medical Exerning must be notified at reumate event,

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

and manner stated

25. Was ca referred to medical 1 ☐ Yes 2 ☑ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29a. Certifier

04115

29d. Date signed (Month, Day, Year)

N. Psunt Dir 30. Name and address of person who completed cause of death (Item 3 a) (Type, Print) 14. ROBZRT BIRSCHBACH, WM

201 RUSSZLL AVENUE GAITHERSBURG, MAS 208

129,2010

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 897 6:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13701 Clemerra Way Brandywine Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth _{Yea}1931 r 24, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Director 579-38-6088 78 Washington, D.C November Usual Residence of Decedent 28a-f shov 10a, State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 12512 Cambleton Drive 20774 United States items within 72 hours after death Was Deceud.
Armed Forces?
Yes 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Office of the Architect Elementary/Seconday (0-12) College (1-4 or 5+) Bailor 12th grade the Capitol Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic onee. Charles James Jackson E11a Mae Dabney traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Mae Jones Jackson (Wife) 12512 Cambleton Drive; Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Cisposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland Inc. signature o Funeral Serv Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yech line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 **N**o 잍 1 🗌 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 I DO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Cescribe how injury occurred (Month, Day, Year) 1 Natural 5 Pending after death.

Director: Aft d in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ame and address of person who completed cause of Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oscar Villiard Jackson 94 2010 20:21M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8 Date of Birth 9. Birthplace (State or Foreign 1 X M 2 Days Hours 579-14-7149 0971871920 Wash., D.C. **Director** 89 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Seat Pleasant 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6606 Grieg Street 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 43- 44 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural", Completed 3 ☐ Widowed 4 ☑ Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12th Custodian <u>Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental | 27 is marked o traumatic eve Mental Oscar B. Jackson Corine Alberta Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia A. Carter/Daughter 3004 Gallery Place, # 31, Waldorf, Maryland 20602 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 05/06/10 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death End stage Renal disease Physician, disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 3.242.2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine PArkinsons Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical ype II sianetes Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 📆 No Other: 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide To the Hospital within 24 hours a To the Funeral C completed filled Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) mukamii Abdella mo 000599 61 52/10 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukemil applella 3001 Hospital Drive, Cheverly, Maryland 20785 UFTI ,

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

MAY 0 4 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MANTAL 348 M NORMAN **JOINES** 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death. REGIONAL HICIMICO TENINSULUA 54436UM Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth **Funeral** (Month, Day, Year) L 31,1924 1 X M 2 🗆 F Months Davs Hours **Director** 222-10-6523 85 JUL PHILA. PA Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Director 10d. Inside City Limits MARYLAND WICOMICO COUNTY SHARPTOWN, MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 707 CORPORATION ROAD 21861 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) PROCESSING PLANT. College (1-4 or 5+) 12 GENERAL MANAGER **AGRICULTURAL** Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ ELIAS JOINES CLARA CALLOWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY M. JOINES (WIFE) P.O. BOX 233 SHARPTOWN, MD 21861 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State FIRST STATE CREMATORY MAY 4,2010 4 Donation 5 Other (Specify) MILLSBORO, DE 22. Name and Address of Facility 19966 MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, dreomplications that c shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner ASC Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the intrinsicient To the Hospital or Attending Physician: The law requires that the death certificate be executed tran and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours aft

To the Funeral Dir

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse 3[only one) Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 2010 30. Name and address of per eath (Item 23a) (Type, Print) pleted cal

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State Registrar PARNOLL St. SALISBURY MILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Barnes Judd April 2010 3:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 620 Holiday Drive Pocomoke City Worcester Social Security Number If Under 2 7. Age (In yrs. last birthday) 8. Date of Birth Year **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 □ M 2 🔀 F Months Days Hours 1938 Virginia **Director** 230-48-1513 Nov. Usual Residence of Decedent 28a-f show with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 620 Holiday Drive 21851 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Cataloque Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Stephen Randall Barnes Doris Kellam permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Holiday Drive, Pocomoke City, MD 21851 Robert W. Judd (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 5/4/2010 Liberty Cemetery Parksley, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses HôlToway drufferal Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown detached g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed⁴ this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After injury Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) April 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:30pM hae Edivara Johnson Apri 2010 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woods esapeake ambrida Dorchester Center Birthplace (State or Foreign Country) 5. Social Security Number 214-42-9 If Under 24 Hrs 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F Months Days Hours Min. 1945 Maryland Director JAN. 24 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be redified at 1 Yes 2 No Director ambridg 10f. Zip Cod 10e. Street and Number 10g. Citizen of What Country? OCUST Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify: 2 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Ire Magnes, once. should be filed within College (1-4or 5+) Elementary/Secondary (0-12) 12 Hotel usekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Vera ဂ္ 01 Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph CUST ambridge, MD.21613 20b. Place of Disposition (Name of cemetery, crematory or other place)

M d Shore Cremat 20a. Method of Disposition Date 20c. Location City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State hore Crenation ambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry Funeral 21. Signature of Funeral Service Licenses Home, P. MD.21613 510 54, washington 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final alure S **Physician** disease or condition resulting in death) 0.0 /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending PhysIclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? iting to death but not resulting in the underlying cause given in Part I. Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 004000 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a, Was an ٠١-٥ has autopsy certificate 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**90** No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 12 Natural 5 Pending investigation e Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. D69234 03 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

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MAY 04 2010

ERRASOW MD, 503 BYRN STREET

CAMBRIDGE, MD 21613

Registrar
DHMH 17 Rev 1/2001

nickroville no 21108

Veteransting

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Modb5 20^Y10 8:00 A M Gideon Musyimi Kioko Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 8301 Osage Terrace Adelphi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
11-21-1939 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 🗆 F 060-36-0823 Director 70 Kenya Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Prince Georges Adelphi 1 ¥ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral death with 20783 USA 8301 Osage Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene. Completed by 1 Never Married 2X Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: African Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hospita1 Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked otl Esther Nzuu Paul Kioko 19a. Informant's Name/Relationship (Type, Print) Wife-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 8301 Osage Terrace, Adelphi, MD Johnette Anderson-Kioko 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department or Important: If any Injury or Riverdale Park 05-04-2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune al Service Licenses Ralph Williams, II Funeral Service, P.A. 5202 PrincetonsDelightDr. Bowie, MD 20720 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IRRHOSIS LIVER Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate It 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Donald George, State

29b. Signature and title of certifier

MAY 0 4 2010

7500 Hanover Pkwy.; 31. Date filed (Month, Day, Year) 32. Registrar's Signatus

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Suite 101A

Greenbelt, MD

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Day 201^Y0^a **Physician** Carol Ann Koontz 1 9:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3601 Shiloh Road Carroll County Hampstead 8. Date of Birth (Month, Day, July 28, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** , 1956 Maryland Months Days Hours 1 □ M 2 🛛 F 218-74-4719 53 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □ Yes 2 No Maryland Carroll County Hampstead Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3601 Shiloh Road United States 21074 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X If Yes, Give Year or Dates: 10. 1 Never Married 2 ☐ Married Specify: white 1 □Yes 2 →No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If flem 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Sheltered Workshop Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion E. Wehe Franklin Norris Koontz, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Shiloh Road Hampstead, Maryland 21074 19a. Informant's Name/Relationship (Type. Print) Marion W. Koontz / mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 6, 2010 Finksburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home Hampstead, Maryland 21074 934 South Main Street M01072 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) Pregnant at time of death the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident n by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

of Vital Records, P.O. Box 68760, Division Hospital or Attending 24 hours after death. filled completely within 2 ٥

WJL 3 State

Medical

29a, Certifier

(Check only one)

OU

29b. Signature and title of certifier

30. Name and address of person

Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 2010

WBelvedere Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2010 NATIVIDAD GUIZAR KUNKOWSKI 2241 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Days Hours Min. october 20, HONDURAS 1928 Director 527-46-7426 81 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a, State death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MARYLAND QUEEN ANNE'S **STEVENSVILLE** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 830 DIXON DRIVE 21666 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after WHITE If Yes, Give Year or Dates 1 X Yes 2 ☐ No Specify: MEXICAN Specify: "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) FEDERAL. Elementary/Seconday (0-12) College (1-4 or 5+) 12 MICRO FILM SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherked o ည permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. ISAIAS GUIZAR ELIGIA ISABEL MARIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE TIERNEY/DAUGHTER 409 FRIENDSHIP DRIVE, CENTREVILLE, MARYLAND 21617 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cernetery, crematory or other WOODLAWN
MEMORIAL PARK other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician intracerebra disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 1 Yes 2 L 9 Unknown PO signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

24 hours

State Registrar 29a. Certifier

29b. Signature and

30. Name and address

31. Date filed (Month, Day, Year)

3

e of certifier

on who completed cause of death (Item 23a) (Type, Print)

32. Re

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MC 2001 Medical Parkway, Annapolis, MD 21401

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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38	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 Never Marri 3 Widowed		Armed Forces?			Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎛 No Specify:				Rican, etc.)		14. Race - American Indiar Black, White, etc. Specify: White		tc.	
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アひと / 304pm Baltimore, Maryland	permit. Page 1 and 2 s Department of Health a Important: If item 27 i any injury or other tra		1 🖫 Burial 2		☐ Removal from State		Place of Dispo cemetery, cren conons UN	natory or c	other place		05/05,	⁰ ate /2010		ocation - Ci	-		
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Ž	the Hospi thin 24 hou the Funer mpleted fill	Medical	(Check 2		hysician: To the best of iminer: On the basis of e urse Practioner: To the	xaminatio	n and/or invest	igation, in	my opinio	n, death or	ccurred at	the time, date	and place	e, and due to	the cau	se(s) and manner:	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2010 Gladys Christopher Larmore April 27 12:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genesis HealthCare-The Pines Easton 8. Date of Birth (Month, Day, July 6, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 199-03-9415 102 1907 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Director MDEaston Talbot 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 610 Dutchman's Lane United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2**X**ONo White Specify: ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sportswear Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William R. Christopher Suda Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7379 Swan Point Way, Columbia, MD 21045 June Christopher Garber/Niece Department of Health Important: If item 27 any Injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 04/30/10 Easton, Maryland Spring Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No N 20 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Marsing Home 5 Residence 6 Other (Specify) 1 Mes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation April 20 2010 FALL 1 ☐Yes 2 € No 2 Accident 6 ☐ Could not be 3 Suicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

and burial-trai

attending physician for use as the buria

sate has been signed by the page 2 should be detached

this certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

the Maryland

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Macigal Examinating man by notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or Items 23a or

Baltimore, Maryland 21215-0036

Certification: To 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NUISING HOME PINESIEIO DUTCHMANS LN MD 21601 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number **P** 133336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CIODUTCHMANS CANE B. JENSEN MD, POB# 690, DAUTON MD 21629 HAISTIAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #16b, per Fh g903 5/21/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>2</u>8^{Day} April Physician/ 1:00 a M Lewis Samuel Lane 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 20.1943 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country rginia **Funeral** Min. Hours 66 Months 227-56-1215 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Perryville 1 Yes 2 X No Maryland Cecil 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21903 35 Creswell Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry So Gran, Inc. Edgewood, Maryland 15 Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Twelve Years College (1-4 or 5+) Technician ag Laboratory Ith and Mental Hygien 27 is marked other the traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jenny Glasco 2 Louis Lane permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Creswell Lane, Perryville, Maryland 21903 19a. Informant's Name/Relationship (Type, Print) (wife) Vera Eklund Lane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A.Ferris & Co..inc. 20c. Location - City or Town, State West Chester. Pennsylvania 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/29/10 4 ☐ Donation 5 ☐ Other (Specify) Lee A. Patterson & Son Funeral Home. Inc. Perryville, Maryland 21903-0766 21. Signature of Funeral Service License * Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Glioblastoma Multitorne months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant a Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? certificate 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) How 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Tes ြုင this 24 hours after death.
Funeral Director: After thieted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 Jut CRNP April 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Thales SK Towson N. 21204 Marian Grat C>01 31. Date filed (Month, Day, Year, 32. Registrar's Signature State MAY 0 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / State Registrar	•	tment of Healt ficate of Deat		, ,	ne . No. 2 A I A	10000			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			Mon	of Death th	Day Year	3. Time of Death			
	Medic	al	Robert E. Lee 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locati		oril :	29, 2010 4c. County of Death	1:58PM ^M			
4	Examin	er	6111 Bison Court		Waldorf	ion of beating	Charles					
ı	Funeral Director		5. Social Security Number 6. Sex 1 A 2 F 7. Age (in yrs. last bit		If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date rs Min. (Mon Sept	of Birth oth, Day, Ye	9. Birth Cour 1927 Mor	place (State or Foreign ntry) tana			
	aryland a-f show fied at	Funeral Director	Montana	10c. City, Town or Location					10d. Inside City Limits 1 □ Yes 2 🛣 No			
	or 28:	Dire	10e. Street and Number	e 	10f. Zip Code			1 ☐ Yes 10g. Citizen of What Country?				
	n with nust b	neral	1854 Dewey Blvd.		59701		Un	United States				
920	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates.	- 1	is Decedent of Hispanic res, specify Cuban, Mex Yes 2 XNo Spe		or No- c.)	14. Race - Americ Black, White, Specify: Wh				
2-0	2 hour "natur edical	plete			nt's Usual Occupation	most of working	16	b. Kind of Business Ir	dustry			
21215-0036	vithin 7 liene. sr than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	Ìife. DO I	NOT use retired)			TRFW				
pu	filed v tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	_1666	i i	other's Name (First, M	liddle, Mai					
Maryland	buld be fill d Mental marked o matic eve	인	Jeremiah Patrick Lee 19a. Informant's Name/Relationship (Type, Print)			ry Theresa						
	2 sh th an 27 is trau				Address (Street and Nu				Code)			
Baltimore,	m 0		20a. Method of Disposition 20b. Place 20b. Place cemet	of Disposit	tion (Name of tory or other place)	Date	20	c. Location - City or T len Bernie				
Balt	permit. Page Department Important: I any injury o once.		21. Signature of Funeral Service Scensee Moll90	1.	Name and Address of Fa	acility Huntt	Fune	ral Home	20601			
	Fnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	y or		n as cardiac or respira		Phel	Approximate Interval Between Onset and Death			
160	icate be executed physician and sthe burial-transit	fedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within E4 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed					u. Was an autopsy performe	n 24b. Were autopsy findings available prior to completion of cause of death?				
Vital	/sician: The law s certificate has t director, page 2 s	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient	26. Place of Other:	Death (Check only one	a)	No 1 Ves Da e 6 X Other (Specif				
on of	ath. r: After thi	Certificate: 1	27. Manner of Death 12. Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b.	Time of injury	28c. Injury at work? M 1 Yes	28d. Des	cribe how	injury occurred	y nouse			
Divisi	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, the building, etc. (Specify)	farm, street	t, factory, office			ition (Street and Number or Rural Route Number, or Town, State)				
	the Hospi nin 24 hou the Funeri Tpleted filli	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and 3 Certifying Nurse Practioner: To the best of my knowledge	d/or investig	ation, in my opinion, dea	th occurred at the time	date and	lace, and due to the ca	ause(s) and manner stated.			
	To with		29b. Signature and title of certifier	M	29c. License numb	2 g	29d	Date signed (Month,	(Jay, Year)			
	BB5		30. Name and address of pelson who completed ause of death (Item 23a)	ype, Prir	MP. WI	From	$C_i \mathcal{N}$	os la	F3			
	Sta Registr		31. Date filed (Month, Day, Year) 32010 32 Registrar's Signature	pa	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr i1 2**0**TO Physician/ 1:30 p м Ardeth Pennington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge 203 Mill Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Sept. 22, Hours Days Months ^{∍ar)}1923 Kentucky 86 404-20-3554 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland the Medical Examiner must be notified at Director Cambridge MD Dorchester 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 28a any injury or other traumatic event, the Medical Examiner must b 21613 Funeral 203 Mill Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ 🗌 Yes 2 🙀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) railroad secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha unknown ည John Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Mill Street. Cambridge, MD 21613 19a. Informant's Name/Relationship (Type, Print) 203 Mill Street, Cambridge, MD husband Otis Lloyd Jr. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 4/30/10 Delmar, DE Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. ators of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Dea h Immediate Cause (Final breast months Physician/ metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner squentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director, After this certificate has been signed by the attending physicia Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Vear Day Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementa 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? page 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at 28d. Describe how injury occurred Certificate: 1 X Natural work' 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address a 31. Date filed (M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHIRLEY B. MAKER APRIL 7:20 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) APRIL 24, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months 80 201-22-8063 **Director** 1930 PENNSYLVANTA Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MARYLAND 1 X Yes 2 No CECIL ELKTON 10e. Street and Number 10f Zip Code 9 10g. Citizen of What Country? Funeral 23a 109 MARLEY ROAD 21921 UNITED STATES items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the..." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CASHIER 12 DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) COLEMAN JOHNSON ESTELL HAYWOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERI M. DUPREE / DAUGHTER P.O. BOX 110, RISING SUN, MARYLAND 21911 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. CARMEL CEMETERY 05/08/10 NORTH EAST, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): iabete Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 🗌 Yes Yes **Division of Vital** 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Gertifying Nurse Fractioner: To the best of my kno 29b. Signature and fitle of certifier 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

31. Date filed (Month

CRU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ May 2010 10:15 AM Marianne McClure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital g. Birthplace (State or Foreign Country) Lancaster Pennsylvania If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** (Month, av 3 Days Hours Day, Year 1 □ M 2XX Director Ĩ932 Mav 211-24-6491 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Tes 2 No or 28a-f Rising Sun <u>Maryland</u> Cecil 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21911 United States 347 Crothers Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Technician Medical permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julia Quino Ralph Lester Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Crothers / Daughter 347 Crothers Road, Rising Sun, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Auburn Regular Baptist Cemetery 1 Burial 2 Cremation 3 Removal from State Landenberg Pennsylvania 4 Donation 5 Other (Specify) May 6, 2010 22. Name and Address of Facility Crouch Funeral Home 21. Signatur 127 South Main Street, North East, Maryland 21901 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Un Livus Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 □ Probably 4 ☑ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 🗖 Natural work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Menth, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0630 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Harwood Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1944 Months Dec 25, Director 220-42-3088 Massachusetts 65 Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2986 Dogwood Trail United States 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ģ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Completed 3 - Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) the Mortgage Broker Mortgage/Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o and Mental marked မ Randall Sullivan Cecile Lafond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen S. Shepherd/sister 121 West Bay View Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, 4 Donation 5 Other (Specify) Final Journey Crematory 5/6/2010 Woodbine, Maryland 21. Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M thomas M00957 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 Ho
9 Unknown • Hospital or Attending Physician: The law requires that the deat 24 hours after death.
• Funeral Director. After this certificate has been signed by the selected filled in by the funeral director, page 2 should be detached it 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 \square No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **2** Ro Hospital: Other: ျာ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State Registrar

DHMH 17 Rev 7/2009

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#26 per PHY State of Marylan State 4/28/2010 AACO HEALTH DEPT OMH Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Muhl Physician/ Mariorie M. April 2.4° 2017 Αм 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Autumn Meadows Assisted Living Gambrills Anne Arundel 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day 1 □ M 2 🔀 Days Hours Min 92 208-03-3321 **Director** 1917 Nov. Pennsylvania Usual Residence of Decedent Show 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director Anne Arundel Annapolis 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 903 Breakwater Drive 21403 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian r than "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3

Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 let of Health and Mental Hygiene.

E: If item 27 is marked other than "reor or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Petroleum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Mackey Lvda Crisswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Huyett / Daughter 903 Breakwater Dr., Annapolis, MD 21403 permit. Page 1 and 2 a Department of Health Baltimore, : If item? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/26/2010 Metro Crematory Baltimore, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Heare Medical Due to (or as a conse un nce of) Examine GATCI 6687146 Sequentially list conditions, if any, leading to firm educate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed TRIAL CARS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by TOREAST 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed been s Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Assisted -6 X Other (Specify) Living 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 R After this the Funeral Director: After thin pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ➢ Natural injury 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 140047494 4/26/2010

Registrar
DHMH 17 Rev 7/2009

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TRIVE

ANNAPOLIS, MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANGSTON

32. Registrar's Signature

MONIGORG

31. Date filed (Month, Day, Year)

10-03397 Roland Rayburn	Mc	Please Type	e of Marylar	nd / Depa	artment of	Health an	e All C	opies / tal Hygi	Are Leç ene	gible.		500	
		1- For State Registrar WCHD/SH 5/1. 1. Decedent's Name (First, Middle,Le	3/10 Per	FH Cer	rtificate of	Death				g. No. 4	U	Time of Death	
Physicia Medical Exami		Roland Rayburn		y, Jr.				N	lonth ay 3, 201	Day Year		0925 hrs	
		4a. Facility Name (if not institution, g			1	4b. City, Town, o				4c. County of			
		11010 Coffman Avenue	Ca 17	7 A=0 (le ::== 1	and brieffedous	Hagerstown If Under 1 Year If Under 24Hrs			Data of Birt	Washingto		place (State or	
Funeral Director			Sex 7	7. Age (In yrs. I 49		Months Day		Min.	Losz 1	1,1960	/DD/YYYY) 9. Birthplace (State or Foreign Mary Late of Country)		
		Usual Residence of Decedent	AM ZF	TIS	Yrs.				1,1900				
r any		10a. State 10b. County		1	Town or Locati							0d. Inside City Limits	
land f shov	ğ	Maryland Washing	ton Count	ty Hag	erstown				17:	ng. Citizen of Wha		1 ☐ Yes 2 ☒ No	
the Mary sa or 28a-	Director	10e. Street and Number 11010 Coffman A	ve.			10f. Zip Code 21740			10	y?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Deced Armed For 1 Yes ed If Yes, Give Year		lf Y	s Decedent of Hi es, specify Cuba Yes 2 X No	n, Mexican,			White,		n Indian, Black,	
urs aft tural"	d by	15. Decedent's Education (Specify	or Dates:	completed)	16a. Deceden	t's Usual Occupa	tion (Give I		done	16b. Kind of Busin			
6 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4	4 or 5+)		ost of working life		use retired)		D 1 1	0		
within grene.	d mo	17. Father's Name (First, Middle, La	4		Comput	er Anal		a Nama (Fire	t Middle M	Federal	. GOT	ernment	
21215-0036 und be filed within ? Mental Hygiene, marked other than	BeC	Roland R. McShe:	•					ie McS					
21; ould b d Men s mar	2	19a. Informant's Name/Relationship	(Type, Print)			Address (Street and Number or Rural Route Nur				nber, City or Town, State, Zip Code)			
MD nd 2 sh alth an m 27 i		Jeanie McSherry 20a. Method of Disposition	-mother	Laon I		Box 467		iamspo Da		D 21795 20c, Location - C	itu os To	um Ctata	
Baltimore, MD vernit. Pages 1 and 2 sho Department of Health and important: If item 27 is njury or other traumati		1 Burial 2 Cremation 3	Removal from	n State	crematory or oth		Powle	5/8/2 4-8-2	010		•		
Itim iit. Pag urtment ortanti ry or o	-	4 Donation 5 Other Special 21. Signature of Funeral Service Lice	fy: ensee	Ced		ame and Addres				Fiery I		Maryland	
Ba Perm Injuri	1	Dundant	Fair	U				0		Hagerstov		MD 21742	
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	pplications that cau	ged the death.	. Do not enter th	ne mode of dying	such as ca	ardiac or resp	oiratory arre	st, shock, or heart		Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Atherosclero			ease						Death	
**		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b											
	iner	if any, leading to immediate	Due to (or as a c	onsequence of	ence of):								
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Records, P.O. Box 68760, The law requires that the death certificate be execut cate has been signed by the attending physician and page 2 should be detached for use as the burnal - trax	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birt		2 Fet	al death 3	Ectopic	pregnancy		23d. Date of de Month	Day	Year	
Ox 68 eath certif	/sici	1 Yes 2 No 9 Unknow	,	nt at time of de	ath 5 Oth	ner (Specify)							
		Part II. Other significant conditions			esulting in the u	nderlying cause	given in Pa	rt I.	23e. Did tol	pacco use contribu	ite to the	cause of death?	
ires that signed I be de	d by								1 Yes	2 No 3	Probab	ly 4 🗸 Unknown	
ords w requ is been should	Completed								24a. Was a autops	sy prio	or to con	sy findings available pletion of cause of	
Rec The la cate ha	E							1	yerform ✓ Yes 2		ath? ✓ Yes	2 No	
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	Be (25. Was case referred to medical examiner?	Hospital:		ED/O to Fort		Othor	Check only o			011 - 0		
of Vi g Physics her this eral di	<u>ار</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	oatient 2	ER/Outpatient 28b. Time of Ir		ry at Work?	Nursing Hor		Residence 6 🗹		cene	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	3 Suicide 6 Could no	t be 28e. Place	of Injury - At ho	ome, farm, stree	t, factory, office b	ouilding, etc		Location (Stor Town, St		or Rural	Route Number, City	
ospital hours aneral		4 Homicide determin	1-7//	of my leasure 1	an doath	and at the time.	oto e - d · f				·		
Division of Vital Record To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page 2	Medical	(Check only	cian: To the best of er: On the basis of	examination ar								ause(s)	
To vin	Me	29b. Signature and title of certifier	and manner sta	. A		29c. Licens	e number			29d. Date signed	(Month	, Day, Year)	
		Calle	M	171	- 1	O.C.	M.E.			May 4, 2010			
		30. Name and address of person who	completed cause	of death/(Item	23a)								

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State 31. Date filed (Mon) Av Y 2010 32. Registrar's Signat

Rogistrar's Signature

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ward Daisey Murray ADIL 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO SALISBUN TENINSULA KEGIONAL 9. Birthplace (State or Foreign Country) DE If Under 1 Year If Under 24 Mrs 8. Date of Birth **Funeral** Days 2(1/91t/1/19443ar) 1 🛛 M 2 🗆 F Months Hours 67 222-26-6199 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA 229 West St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Esther Townsend Milton E. Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 West St., Berlin, MD 21811 Fay Murray / wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State 4/30/2010 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Mctastan Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 5-color fielly list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 2 No sate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: death? 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at iniurv work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

24 hours after death.

Funeral Director. After this certificeted filled in by the funeral director,

BA 5+1

within 2 To the F

Medical

29a. Certifier

only one)

31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1008. CAKRUI

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 4.30.10

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 3. Physician/ 2010 John Francis Martin 8000 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₩ M 2 🗆 F Hours 05/31/1923 Country) ew York Director 078-14-4781 86 New Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 M No Maryland Calvert Lusby 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 20657 12805 Bay Drive 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: 3 Widowed 4 Divorced White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Commander Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Boyd John Michael Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 12805 Bay Drive, Lusby, Maryland 20657 <u>Jane Flinn Martin / Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory 05/04/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onest and Death Immediate Cause (Final Physician/ la disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami been signed by the attending physician and should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Physician: The 1 ☐ Yes 2 ☐ No this certificate 2 NO Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Tes 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Alatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. I Director: Aft 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination target and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

State Registrar

Box 68760

P.O.

Records,

Division of Vital

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Date filed (Month,

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2010

Frederick, MD

			For State	State of Maryla	and / Dep	artment	I nk. Ensure All of Health and M of Death	ental Hygi	ene U	ble.	5529
			Registrar 1. Decedent's Name (First, Middle, La	ist)		rineate	OI Dealii	2. Date of Death			3. Time of Death
9	Physic		RAHIMA	Mustafa				Month 4	Day 30	Year	11:37 PM
1	/Medi Exami		4a. Facility Name (If not institution, gi			4b. City, To	wn, or Location of Death		4c. County		11 011
*	Examil	ier	14109 ARMILLA	CT.		BURT	OHSVILLE		Mo	NTGO	MERY
	Funeral	100			rs. last birthday,	If Under 1	Year If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreig
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	with the Maryland is or 28a-f show Log rollfied at		10a. State 10b. County	10c.	City, Town or L	ocation				10	Od. Inside City Limits
	Man	tor	MO MONTGO	MERY	BURTO	MSVII	J.F				1 Yes 2 □ No
	r 28g	Funeral Director	10e. Street and Number			10f. Zip C		10	g. Citizen of \	What Coun	try?
	h with	ie D	14109 ARMILLA	CT.		20	366		BANGIL	ADE	SH
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	Hyginather ant, I	Ü	17. Father's Name (First, Middle, Las	")			18. Mother's Name	(First, Middle, N	faiden Suman	-	
an	id be ental ked c	To Be	MOINUL HO	. <i>ල</i>			RAFIG	SCIN .	NEGA		
Maryland	should by nd Menta marked	-	19a. Informant's Name/Relationship	(Type, Print) (SON)) 19b. Mail	ing Address (5	Street and Number or Rura		City or Town,	State, Zip	Code)
N	nd 2 sho alth and 27 is m ir traum		MOHAMMAD FAROS		1410	A Apr	nius Cr. I	BIETNALS	Juli	no	20866
altimore,		1	20a. Method of Disposition	20	b. Place of Disp cemetery, cre	osition (Name	of D		20c. Location		
Ę	Page ent o nt: if ry or		1/3 Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	Removal from State		•	GARDEN 5/1	12010	FREDE	RILL	MO
alti	permit. Page Department o Important: If any injury or ance.		21. Signature of Funeral Service Lice				SERVICES				
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	a F .		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	polications that caused the d							Approximate Interval Between
	Physician		Immediate Cause (Final	^	1	1/10	1 /	1 1			Onset and Death
2	/Medical		disease or condition resulting in death)	a. Cancer Due to (or as a con	sequence of):	IFIC	parage a	and to	ongu	-	years
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		ē	Sequentially list conditions, if any, leading to immediate				-				
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a con							
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Вох	death certificate b rattending physic d for use as the b	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Te			23d. Da	te of delive	огу
	death e atten	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F		⊒Ectopic preg ⊒ Other (s <i>pec</i>			Mo	onth	Day Year
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	requires that the de een signed by the a nould be detached t	Y P	Part II. Other significant conditions	contributing to death but not	resulting in the I	underlying cau	se given in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
ds	uires 1 sign	D D						y Ye	s 2 No	3 Prob	ably 4 Unknow
Ö	> 0 to	ete						24a. Was ar	24b.	Were auto	psy findings availab
Records,	e la has	Completed						autops	y led?	prior to cor death?	notetion of cause of
a	ician: Th certificate rector, pag		05 116						7	1 🗆 Yes	2.20 No
Σ		Be	25. Was case referred to medical examiner?	Hospital:	- C = 2 12		Other: 4 Nursing Hor	11			
of	Phys this ral di	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatie		4 Nutsing not	ne 5 A Reside 28d. Describe ho	nce 6 Oth		0
L	ding After funer	ion	1 Natural 5 ☐ Pending	(Month, Day Yea	r) Injury	M 280	: Injury at Work? 1 ☐ Yes 2 ☐ No	DOJUNDO NO	injury occur	.50	
isic	death death stor:	icat	2 Accident investigate 3 Suicide 6 Could not	De 28a Place of laive.	At home form =			28f. Location (Sti	reet and Numi	ner or Rum	I Route Number
Division of Vital	e Hospital or Attending Pi 24 hours after death. • Funeral Director: After ti etely filled in by the funera	Certification:	4 Homicide determine		ecify)	ueer, ractory, o	Jinde	City or Town		or or mura	THOUSE NUMBER
_	pital purs aral		236 Cartifier 1 Certifying P	husteines To the boat of mil	kanuto dan dan		to your date of the	end description			mr. d
	24 ho Fun Fun	dicai	(Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	nination and/or in	nvestigation, in	my opinion, death occurr	ed at the time, da	ate and place,	and due to	the cause(s)

State Registrar

10115/0 31. Date filed (Month, Day, Year) MAY 0 3 2010

N e and address of person to completed cause of death (Item 23a) (Type, Pri t)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 2010 3:05AM Norma P. Morgan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year 07 04 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Days Hours Min. Country Director 577-48-3346 78 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director notified 1X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 818 Longfellow Street 20011 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3X Widowed 4 □ Divorced Black Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic even Health and Mental ည Norman Redman Lacie Holston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 K street Washington,DC 20002 Anita Morgan-Williams/Daughter Department of Health Important; If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery: 05 04 2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Pervice License 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ minutes Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner minutes Cerebral Anoxia Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death ate has been signed by the apage 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending after death. 2 Accident
3 Suicide 1 Yes 2 🗆 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Godffying Nursa Practioners To the Sest of Tylina dat the time 29b. Signatu 29d. Date signed (Month. Day, Year)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of p

MAY 0 4 2010

rson who completed cause of death (Item 23a) (Type, Print) Gunta, MD 9801 Georgia Avenue #2 Silver Spring, MD 20902 Suresh K.

Registrar

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2010

Please Type or Print in Black Indelible Ink Firsty All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20<u>10</u> Physician/ April 6:25A 24 Mark David Meinersmann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Min. Hours Sep. 25, Year 1957 South Carolina 221-46-5481 52 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 **X** Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20720 USA 12819 9th Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 2+ Elementary/Seconday (0-12) Printer Private Sector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosali Bronenkant Herman Meinersmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12819 9th Street Bowie, MD 20720 Laurie Petty/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/2/2010 Glen Burnie, MD Crematory uneral Servi 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD †nysician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ϵ completed filled in by the funeral director, page 2 should be detached 1 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No ျ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and titl of c 29c. License number 58289 4-26-10 el mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffery Hoeck 4175 North Hanson Court, Ste. 203A - Bowie, Md. 20716 31. Date filed (Month, Day, Year) 9 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maultair 9:47D M May 04 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Lambard Medical Center Baltmore If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days oct. 14, Year 1974 1 M 2X Hours Min. Country) 204-66-4201 35 PA Director Usual Residence of Decedent ms 23a or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Silver Spring Montgomery 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20900 1443 Harding Lane U.S.A. items 2 within 72 hours after death Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black White etc and 2 should be filed within 72 hours after d Health and Mental Hygiene. em 27 is marked other than "natural", or i 1 Never Married 2 Married ۵ Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Law enforcement Police Officier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael R. Maulfair Toni R. Agresta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 104 Gearhart St., Millersburg, PA 17061 Toni R. Maulfair permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May cemetery, crematory or other place) 1 D Burial 2 K Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Hoover F H & Crematory 2010 Harrisburg, PA J, J. Hartenstein Mortuary Inc 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility any Second St. New Freedom, PA 17349 Ech 24 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avaft Physician Versi SPASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to know distance cause. Enter Underlying Examine Durate (or as a our sequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Pregnant at time of death Day Year 5 Other (specify) Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA မှ Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending hin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

saltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ מי Michael Hortense Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland 9. Birthplace (State or Foreign Country)

MD Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 □ F Min. (Month, Day, Yo Months Hours Director <u> 218-16-3577</u> 85 Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Allegany MD Cumberland 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21502 USA 12 Marion Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced white Completed be filed within 72 hours ntal Hygiene.

Red other than "natura" sevent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tht any injury or other traumatic event, the I own home <u>homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aubrey C. Phillips Elmira M. (Neat) Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland MD 21502 granddalu. 12300 Bowling Street Shanda Deatelhauser 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 5/15/201D Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of uneral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/) { disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 MProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1025 ひのひと 2 X No 1 • Hospital or Attending Physician:] 24 hours after death. • Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☑No 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \quad 2 \(\text{No} \) 1 Natural 5 Pending iniury Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗷 ፍ rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2010 CHEN 031875 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .450 CUMBERLANDIMD 21502 12502 WILLOWSROOK RD STE

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Edward Henry Martin, 2010 \mathbf{A}^{M} 2:22 28 April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Berlin Nursing & Rehab If Under 24 Hrs. 8. Date of Birth (Month, Day, 4-19-1 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Hours Min. Months 1 🕱 M 2 🗆 F 89 214-28-8039 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21863 103 Federal Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. SpecifyBlack 3 x Widowed 4 ☐ Divorced Year or Dates. 1940 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Paul Jones Elementary/Seconday (0-12) College (1-4 or 5+) Lumber Co. 12 Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Collick Rueben Martin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, MD 21801 905 Hanover St. Cynthia Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 17 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Veteran's Cem 5-5-2010 Hurlock, MD Donation 5 Other (Specify) 917 W. Isabella St. e Funera Pervice Licensee 22. Name and Address of Facility Bennie Smith Funeral Home Salisbury, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death l Thermers stage Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Medical

Director

Funeral

Completed by

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Be Completed by Physician/Medical Examiner

Certificate: To

Medical

29a. Certifier

(Check

only one 29b. Signaty

and title of certif

Pennie Savage,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

To the Hospital or Attending Physician: The law requires that the death certificate be eximined by the rours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1		-	23d. Date of del Month	livery Day	Year
Part II. Other significant conditions contr	ributing to death but not resulting in the underlying	g cause given in Part I.		death?	robably 4 🕽	Unknow
25. Was case referred to medical						
examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient 3 I	lome 5 - Residence	6 ☐ Other (Spec	ify)		
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28d. Describe how inju				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	28f. Location (Street a City or Town, Sta	et and Number or Rural Route Number, State)			

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2010

April 28,

21811

MD

License number

K1351

Healthway Dr, Berlin,

DHMH 17 Rev 7/2009

State Registrar

9715 32. Régistrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lichael Mendes	R	State of Maryland / Department of Health and Mental Hy -For State Certificate of Death	Re	g. No. 2010	5535
Physiciar Medical Examin	1/ [1. Decedent's Name (First, Middle,Last) Michael Lee Mendes	2. Date of Death Month April 30, 20		3. Time of Death 2120 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7200 Ganeys Wharf Road - Choptank River Preston		4c. County of Death	1
Funeral		7200 Ganeys Wharf Road - Choptank River Preston 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9. Bir	thplace (State or Foreign
Director		214-37-8927 1 Nonths Days Hours Min.	Sept.	19,1992 Ma	ryland
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Federalsburg		············	10d. Inside City Limits 1 Yes 2 No
72 hours after death with the Maryland n "matural", or items 23a or 28a-f show any al Examiner must be notified at once.	Director	10e. Street and Number 27292 Willin Lane		Og. Citizen of What Cou United St	
with the ms 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		ican Indian, Black,
1215-0036 Id be filed within 72 hours after death fental Hygiene. narked other than "natural", or ite	by Funeral	Anever married 2 married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:		Specify.	hite
2 hours a	eted b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. Do NOT use retirementary/Secondary (0-12) College (1-4 or 5+)	red)	16b. Kind of Business/ Stude	
5-0036 led within 7 Hygiene. other than	Completed	11 17. Father's Name (First, Middle, Last) High School Studen 18. Mother's Name			
21215-0036 Juld be filed within 7 Mental Hygiens marked other than te event, the Medica	<u></u>	Franklin Joseph Mendes, Sr. France	s Reed	McDermot	
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R 27292 Willin Lane, Fe	Rural Route Num ederalst	nber, City or Town, State Ourg, MD 24	e, Zip Code) 632
4 E E E		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of Federals bu	
Baltimore, permit. Pages I at Department of He Important: If it injury or other tr	1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Fr	amntom	Funeral	
m នួក្ខិត្តិ Physician	_(Multipue M. Coale Federalsburg, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	MD 216	32	Approximate Interval
Victical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning			Between Onset and Death
LXammer	- 1	or condition resulting in death) Due to (or as a consequence of): b.			
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.			
uted d ansit	 E	events resulting in death) Last Due to (or as a consequence of): d.			
ie be executed ysician and burial - transit	edical	UNPENDED AMENDED		868.7	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	2-I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown	nncy	23d. Date of deliver	y Day Year
P.O. B. ss that the de gned by the detached is		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
duires the signer of the did be did	ted by		1 Yes	an 24b. Were a	bably 4 Unknown utopsy findings available
Division of Vital Records, ra der death. The law requirers after death. The law requirer and the rest of the law requirer and preceden: After this certificate has been simply the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director be a second to the funeral director bear and the second to the funeral director bear and the second to the funeral director bear and the second to t	Completed		autop perfor 1 ✓ Yes	rmed? death?	completion of cause of es 2 No
tal Recian: The certificate ector, page	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursin		Residence 6 🗸 Othe	Casas
1 of Vir ling Physic After this funeral dir	라	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA VIIIel 4 Nursin 27. Manner of Death 1 Natural 5 Pending Apr 30, 2010 Apr 30, 2010 1 Yes 2 ✓ No	28d. Describe	how injury occurred	er; Scene
Sion of trendin death. ctor: A y the fur	ation	2 Accident Investigation		wned in river	ural Route Number, City
Divisitial or Atrus after durs after de ral Direct	Certification:	3 Suicide 6 Could not be determined (Specify) River	or Town S	State)	ank River, Caroline, M
Division To the Hospital or Attenowithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the caus at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
7. iv 6.	₽ B	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mi	onth, Day, Year)
		30. Name and a ress of person who completed cause of death (Item 23a)		1, 2010	
	ĺ	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201		
Sta Registi	ate rar	31. Date file (1) A. Vin Gag Ye 2010 322. Registrar's Signature			

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			For State Registrar	State of I	Maryland		artment of H		ind M		giene	10	155	36		
			Decedent's Name (First, Middle)	, Last)				- Journ		2. Date of Dea	Pate of Death 3. Time of Death					
В	Physici /Medi		Anna Marie Mio	chaelis					l	Month May	02 2			A M		
	Examir		4a. Facility Name (If not institution	give street and number	er)		4b. City, Town, or	Location of	f Death		4c. County		12.30			
			Envoy of Dentor	1			Denton				Caro	line				
п	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	v, Year)	9. Birthp Cour	lace (State or i	Foreign		
	Director		Usual Residence of Decedent		83	3 115.				April 2	25,1927		aryland			
	/land ow at		10a. State 10b. County		10c. City,	, Town or Lo	cation					1	0d. Inside City	Limits		
	Man B-f sh	tor	Maryland Caroline Greensboro										1 □ Yes 2	X No		
	th the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of \	g. Citizen of What Country?				
	23a Ust b	la [12070 Greensbor	o Road			216	39			U.S.	Α.				
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	\$?	3. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)		e - Americ				
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28e-f show ant, the Medikal Examiner must be notified at	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Tes 2 [If Yes, Give Year or Date:			1 ☐ Yes 2 🛣 No	Specify:		,		Whi				
8	tural attural	edt	15. Decedent		5.	16a Dece	dent's Usual Occup	ation			16b. Kind of Bi					
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nd	al Hy l othe	Be (17. Father's Name (First, Middle, I	.ast)				18. Mother	's Name	(First, Middle,	Maiden Surnan	ne)				
yla	Sould & Ment arked arked attic e	To I	Alfred Kenneth	Falahee				Loui	se U	nknown						
Nar	2 sh and Ism raum	ìş	19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street a	and Number	r or Rura	l Route Numbe	er, City or Town,	State, Zip	Code)			
e, 1	is 1 and 2 of Health a item 27 Is other trau		Anna May Smith/ 20a. Method of Disposition	daughter	20h Die	12070	Greensb	oro R						39		
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		1 X Burial 2 ☐ Cremation		ce	emetery, crer	natory or other plac	e) ¦	_	ate	20c. Location -	•	·			
ij	it. Partmen		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Cêm		lle Veter		ay 6	, 2010	Crownsv	ille	Maryl	and		
Ba	permit. Page Department of Important: If any injury or once.		21. Signature out uneral service to			F	leegle and Box 160	d Hel:	fenb	ein Fun	eral Ho	me, ļ	SA.			
	E P E E		23a. Part1. Enter the disease, or	complications that cause	ed the death.	. Do not ent	er the mode of dying	g, such as c	enso cardiac o	oro, Ma r respiratory ar	ry Land	216.	Approximate			
	Physician		Immediate Cause (Final	A A	FOCA		1 .						Onset and De	en ath		
\mathcal{O}	/Medical		disease or condition resulting in death)		as a conseque	ence of):	7 1	442		(1)/			FING	157		
	Examiner		Sequentially list conditions	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									YEAR	25		
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	ficate physis the	edical		d												
Box	leath certific attending p	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d Dat	te of delive	n.			
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant			Ectopic pregnancy Other <i>(specify)</i>					nth	Day Ye	ar		
о. О	at the by th tache	Physician/Me	9 Unknown	9∐Unknown												
Ś	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant condition	ns contributing to death	but not result	ting in the ur	iderlying cause give	n in Part I.	~ (23e. Did to	bacco use cont	ribute to th	e cause of dea	ith?		
Records,	w require been signature	Completed by	HISINLY DK	2000	4700	42CC	CHR E	115 N	<u> </u>	1 🗆 Y	es 2 □ No	3 NProb	abiy 4 □Uni	known		
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בֿ	s affe	Certification:	4 ☐ Homicide determin	building,	etc." (Specify)					City or Tow	n, State)			,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	edical (29a. Certifier 1 Certifying	Physician: To the bes xaminer: On the basis	of examination	rledge, death	occurred at the tim	e, date and	l place, a	nd due to the o	ause(s) and ma	nner as st	ated.			
	the hin 24	Medi	Une)	and manner	stated.											
	7 × 5		29b. Signature and the of certifier	Who ar	~(IN.	and M	29c. License	OS 3	309	74 1	29d. Date signed	(Month,	Day, Year)	6		
J		-	30 Name and address of person w	the completed	doct (the	WGM	2 int			'	(7) ~ 8	3-2	-1010	-		
			PAULI . ZA	ho completed cause of	V Z	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	D D O COMIN	6 ЪА	151	7.404	ED42A	LSE	5426 1	ND		
	Sta	e	31. Date filed (Month, Day, Year)	32 Regis	trar's Signatu	* 1.	41		1	3 - U ·						
	Registra	ar	MAY 05	2010	ma p	A APPROVED	A Second									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Mayh Louise Mears 2010 7:05 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 M 2 X F Months Hours Min. July 8 Year 1918 91 Maryland Director 219-07-7313 Usual Residence of Decedent , or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Cambridge Dorchester 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21613 709 Goldsborough Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 x No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: white Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mollie Wilson William Abbott permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21613 306 Talbot Ave., Cambridge, MD Peggy Spedden daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State East New Market, MD 5/5/10 East New Market Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Rome P.A. 21. Signature of Funeral Service Licensee Hu Iloma 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death 1erminal Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeeth), act. Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery e Hospital or Attending Physician: The law requires that the death 124 hours after death.
Perneral Director: After this certificate has been signed by the atter leted filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Livursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year) Nau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE THANWY BYRN 503 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 28f per me,g903,05/21/2010dbb
Real No.
Real No. 1 - State Registrar Reg. No. 2, Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1924M Donald Edward Myers, Jr. 2010 TPr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 12401 Van Brady Road Prince George's Upper Marlboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours July 12. 1 🙀 M 2 🗆 F Washington DC 65 1944 578 58 0785 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director Upper Marlboro 1 🗆 Yes 2 No Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 12401 Van Brady Road 20772 permit, Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiens I Hygiens I Important: If item 27 is marked other than "natural", or items any injury or other traumatic event the Madical and injury or other traumatic event the Madical and Industrial Indust Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1XX Yes 2
If Yes, Give Black, White, etc. 1 Never Married 2 Married 9 2 No 1966 Baltimore, Maryland 21215-0036 White 1 Yes 2 XXNo Specify Specify 1971 Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald E. Myers, Sr. Roberta Catherine Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 Van Brady Road, Upper Marlboro, MD 20772 Gwendolyn Myers (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State Maryland Veterans Cemetery May 4, 2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shops, or the failure. List only one cause on each line. Approximate Interval Between Onset and Death wound to Head Physician 6 unshot disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? certificate 1 Yes 2 No Yes 2 - No 25. Was case referred to medical examinar?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 hesidence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year)

28b. Time of injury wor 1

28c. Injury wor 1

28c. Place of Injury - At home, farm, street, factory, office filled in by the funeral 27. Manner of Death Shot 28c. Injury at 28d. Describe how injury occurred Certificate: After t 1 Natural himsel 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) **12401 Van Brady Rd. Upper Marlboro, MD** determined 4 Homicide building, etc. (Specify) 120 me within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check digitative time, date and plans, and him to Gertifying Nurse Practioner: To the best of my knowledge, death 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:36 SABRINA AM MAYH 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MEDICAL CENTE INNIVERSITY MARYLAND BAZTIMORE 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 😾 F 0 1 1 3 7 1 9 7 9 Maryland 218-17-6353 31 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5556 Deale Churchton Road 20733 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Packaging Assistant Providence Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Aubrey Mayhew SR Laura Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Walk Sister 5558 Deale Churchton Road Churchton, MD 20733 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 05/12/2010 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fun ple ervice License 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD^e 21401 Tali 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HERNIATION BRANSTEM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death the detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be or 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 19 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Q Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registr<u>ar</u> P24416

STREET, BALTIMORE ND

2010

MD

225. GREEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	l;	State of Ma	ryland		irtment of F <i>tificate of L</i>		and N		giene Reg. No	21111	15540		
	Physicia	ın/	1. Decedent's Name (First, M.								2. Date of De Month	ath		3. Time of Death		
	Medic Examir	cal	Emelia No. 4a. Facility Name (if not institu	zidling	et and number)			4b. City, Town, or	Location	of Death	4	Day 2	County of Dea	33 10' M		
	Examili	ler	Anne Arundel						apol			Anne Arundel				
	Funeral Director		5. Social Security Number 207-14-1301	6. Sex 1 🗌 I			st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da 4/14/	th y, Yea <i>r</i>)	9. Bir Co	rthplace (State or Foreign ountry) PA		
	and show	ě	Usual Residence of Decedent 10a. State 10b. Co.			10c. City,	, Town or Loc	ation						10d. Inside City Limits		
	Maryl 28a-f notified	irect		e Arun	de1			Odenton						1 ☐ Yes 27€No		
	h with the ns 23a or nust be r	Funeral Director	1301 June Dr					10f. Zip Code	211	13		10g. Cit	izen of What Co USA			
036	2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo	Married	. Was Decedent Ev Armed Forces? 1 Yes 24 N If Yes, Give Year or Dates.		If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes ३५५ No	n, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:			
<u>2</u>	The state of the s									ing	16b. Ki	ind of Business	Industry			
2121	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Civil Service											Fort Meade				
The Never Married 2 Married 1 Yes 2xt No F Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father shame (First, Middle, Last) Walter Heimbacher 19a. Informant's Name/Relationship (Type, Print) Jacquelyn Debar Friend 20a. Method of Disposition 15Theurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee								18. Mother's Name (First, Middle, Maiden Surname) Edna Freimuth								
lary	should and N is ma rauma		19a. Informant's Name/Relati		,			g Address (Street a						ip Code)		
e,	and 2: Health tem 27 other tr		Jacquelyn Del 20a. Method of Disposition	oar	Friend			Becknel Sition (Name of	1 Av		denton on Date		21113 ocation - City or	Town State		
<u> </u>	Page 1 nent of ant: If i		1 XXBurial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth		moval from State	ce	metery, crem	atory or other place Veterans	1				-			
Salti	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Servi	ce Licensee		1101	22.	Name and Addres	s of Facil	ityHard	lesty Fu	nera	al Home			
	40 = 40		23a. Part 1. Enter the disease	e, or complica	itions that caused t	he death.		Ridgely the mode of dying	_				21401	Approximate		
م	fiyəlciafi/	F 95	shock, or heart failure. L Immediate Cause (Final disease or condition	ist only one c	ause on each line.								9	Interval Between Onset and Death		
	Medical Examiner		resulting in death)	6 a	Due to (or as a	conseque	ence of):	FAILURI								
		ner	Sequentially list conditions, if any, leading to immediate	b	Due to (or as a	conseque	ence of):	1/17								
	and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last) c	Due to fev en e											
o -	icate be executed physician and the burial-transit	edical E	resulting in death) tast	L	Due to (or as a	conseque	siice oi).									
09/89	ceruincate be executed inding physician and use as the burial-transit	Medi	IF FEMALE:													
Box 6	notine nospital on Autending Priysiciant, the law requires that the death certain within 24 bours after death. To the Funeral Director, After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c.	. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t g ☐ Unknown	Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	4				23d. Date of de Month	elivery Day Ye ar		
Э	ned by e deta	by Pi	Part II. Other significant con	ditions contri	buting to death but	not resul	lting in the ur	nderlying cause give	en in Part	ı.	23e. Did to	obacco u	se contribute to	the cause of death?		
ras,	equires een sig nould b	eted	CHF								1 🗆 '	Yes 21	No 3□P	robably 4 🗆 Unknown		
or vital Records, P.O.	ate has b	Completed	DIPBETE		ATION,	1471	<u> </u>				24a. Was autop perfo 1 \square Yes	osy rmed?	prior to death?	itopsy findings available completion of cause of		
Eg.	certifica ector, I	Be	25. Was case referred to medi examiner?		pital:			Otho		ath (Check						
) TO	arthis eraldir	e: To	1 Yes 2 No 27. Manner of Death		 1 Inpatien 28a. Date of injury 	2	R/Outpatient 28b. Time of	28c. Injury	4 <u>N</u> at		me 5 Resid		Other (Spec	cify)		
0	eath. or: Afte the fun	Certificate:		nding estigation uld not be	(Month, Day,	Year)	injury	work?	? Yes 2□	- 1						
DIVISION	iral or Art irs after d al Direct led in by	al Cert		ermined	28e. Place of Injury building, etc. (ne, farm, stre	et, factory, office			28f. Location (S City or Tow		d Number or Ru	ral Route Number,		
11	the Flost hin 24 hou the Funer npleted fill	Medical	(Check 2 ☐ Medic only one) 3 ☐ Certify	al Examiner: ring Nurse Pi	n: To the best of m On the basis of exa ractioner: To the be	mination a	and/or investi	gation, in my opinio	n, death o	ccurred at	the time, date a	nd place,	and due to the	cause(s) and manner stated.		
	To i		29b. Signature and title of cert		tespitati	T.		29c. License		9 2			e signed (Monti			
	-		30. Name and address of pers				23a) (Type, Pr		94	82		0	7-26	6.9010		
H	-6		SAVANNA	DRASA	o. m	20	01 Med	ical Par	kway	Anna	polis,	MD 2	21401			
	Stat Registra		31. Date filed (Month, Day, Yea	0 2010	32. Registrar's	s Signatu	A. 4	all								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Iva Louise Nelson М 4/27 10am Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month, Day, Year) 10/23/1922 219-40-9625 87 Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health as 23 or 28a-f show 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2x No Anne Arundel Odenton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 574 Rita Dr. 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black White etc. Completed by 1 Never Married & Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oscar Myers Verna Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elzie I. Nelson Odenton, MD 21113 Husband 574 Rita Dr. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Department of H Important: If its any injury or ot once. 1 XXBurial 2 Cremation 3 Removal from State Maryland Veterans Cem 5/3/2010 4 Donation 5 Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 851 Annapolis Rd. Gambrills, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for L in the past 12 months? 5 Other (specify) Month Pregnant at time of death 9 Unknown the detached g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed has been Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 Tes 2 No 2 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 29,2010 D-40251 HOSPITAL DRIVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 OCHANEY PLEN BURNIE, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State

Registrar

APR 3 0 2010

racket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and 10a-c, 10e-f, 16a, 19a, per Inf G904 6/10/10 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nelson April 29,2010 Daniel Richard 12:27 pm м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Medical Center Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **XX**M 2 □ F Months Days Hours Min. 10/03/1933^{ear)} 578-42-1280 76 **Director** Washington DC Usual Residence of Decedent works i iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Washington DC Washington D.C. 1 2 Yes 2 No Highland Beach Maryland | Anne Arundel 10e. Street and Number 1341 Douglass Avenue 10f. Zip Code 10g. Citizen of What Country? 21403 Funeral 20018 U.S.A. Street NE "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Technical Editor Year or Dates the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William F Nelson Parr spould be Louise 19a. Informant's Name/Relationship (Type, Print)
Pamala Nelson Chandler (Daughter)
Pamela Nelson—Chandler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5320 Chesapeake Rd Hyattsville Mt 20781 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State injury or Chambers Crematory May 5,2010 Riverdale Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mason Funeral Service 21. Si nature 5801 Cleveland Ave Riverdale Md 20737 lease, or complications that cause ... lure. List only one cause on each line. **Sepsis** ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. En Approximate Interval Between Onset and Death shock, 9 Immediate dause disease or condition resulting in death Physician/ Medical Due to (or as a consequence of): Examiner Acute Colitis Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 Tes 2 R No 3 Probably 4 Unknown director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No Congestive Heart Failure 24a. Was an autopsy performed? Yes 2 s after death.

I Director: After this certificate the director, pages and director, pages. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🙀 No ၉ 1 L Yes 1 K Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical

 X
 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 ☐ Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 29a. Certifier (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 29,2010 D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saved Elsavvad MD 10110 Molecular Dr Rockville Md 20850 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:00 P 5/4/2010 TWYLA A. NOLLER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** MALLARD BAY CARE CENTER CAMBRIDGE DORCHESTER 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/17/1927 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Country) IOWA Months Days Hours Min. 1 □ M 💥 F 349-20-8668 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 冷 No Director MARYLAND DORCHESTER CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5520 CASSONS NECK RD. 21613 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GRANT RAGAN EVA FAUTH** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKALYN A. NOLLER / DAUGHTER 5520 CASSONS NECK RD., CAMBRIDGE, MD 21613 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) IOHNSON COUNTY MEMORIAL GARDENS 5/8/2010 OVERLAND PARK, KS 21. Signature of Funeral 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Congestive 1 Yes 2 4 Unknown Disense Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Palmonary Nepression Embolsm OSteo Porosis 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Actural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

and burial-trar Division of Vital Records, P.O. Box 68760, the attending physician thed for use as the buria Hospital or Attending Physician: After this after death.

completely filled in by the e Funeral I

3 Suicide

29a Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

A. NARR

6 ☐ Could not be

Funeral

Director

28a-f show

?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event item.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

State Registrar

the

P

Medical

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Bramble

and manner stated.

100

2. Registrar's Signature

30. Name and oddress of person will ompleted cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

Cambridge MD

Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oluyemisi Omolabake Physician/ 2010 Year 2:53p 01ukoga 23 М Olukoga AKA Apri1 Bola Funmilayo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 16145 Parklawn Place Bowie 8. Date of Birth
(Month, Day, Year)
June 27,1962 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🗓 F Days Min. Months Hours Nigeria Director 020-74-8418 47 June Usual Residence of Decedent fshow 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X⊟ Yes 2 🗆 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 USA 16145 Parklawn Place Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Completed by 1 X Never Married 2 Married ☐ Yes Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Real Estate Loan Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Esther I. Odekunle Benjamin K. Olukoga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fummi Balogun - Sister 16145 Parklane Place, Bowie, Md. 20712 Important; If item 2 any injury or other once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) tment of 1 🗓 kurial 2 🗌 Cremation 3 🔲 Removal from State Lakemont Memorial 4/28/2010 Davidsonville, Md. 4 Donation 5 Other (Specify) Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the control IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform within 24 hours after death.

To the Funeral Director. After this certificate Fompleted filled in by the funeral director, page 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \quad Yes Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No Z ☐ Accident3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who WAJEKOD MOWI GLEN BURNIE 2 31. Date filed (Month, Day, Year) State 2 9 2010 Registrar

or Attending Physician: Director: within 24 hours a

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY U 5 2010

29b. Signature and title of certifier

29a, Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CILKARK ARNO 6701 N. Charles Sty 4202 TOWSON ND 21204

32. Registrar's Signature

Karkar no

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:* On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D16189

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28, Day 2010 Year Physician/ Edith Z. Pressman 12:20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital of Silver Spring Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖺 F 022-22-1356 Hours 1*1*776874918 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🕅 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? USA Funeral 3330 N. Leisure World Blvd., Apt. 802 20906 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ☐ Yes _{Specify:} White 1 ☐ Yes 2X No Specify: If Yes, Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates other than "naturent, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Government Be .ilt. Page 1 and 2 shou...
*artment of Health and Ments.
* If item 27 is marked off
**er traumatic evr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marcus Rose Ida Werber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, Dr. Marc A. Pressman-Son 4605 Jasmine Drive Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gdns 04/29/2010 4 Donation 5 Other (Specify) Olney, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Less^{et} Thain 1year Physician/ Severe Aortic Stenosis Medical resulting in death) Due to (or as a consequence of): Examiner More than lyear Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a punsequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown been signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Histroy of Breast Cancer, Osteoporosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Director:** After this certifical in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 ☐ Yes 2 🔀 No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68681 April 28, 2010 10 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charu Maheshwary, MD 1590 Forest Glen Charu Maheshwary, MD Road Silver Spring, MD 20910

Registrar

31. Date filed (Month, Day, Year)

03

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ANNE LANE POWELL APRIL 28, 2010 2237 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 👿 F 62 220-52-8781 27,1948 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2 □ No WORCESTER BERLIN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10115 GREENBRIAR DRIVE 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 WAITRESS/BARTENDER FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROXANNA LANE ROYDEN N. POWELL, JR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROYDEN POWELL, III/ BROTHER P.O. BOX 89, CENTREVILLE, MD 21617 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burlai 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY MAY 4,2010 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 Other (specify) 9 Unknown the significant conditions confibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ∐ Yes 2 No 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient 1∐ Yes 2 10 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

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Physician

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Examine burial-trar attending physician for use as the buria Physician/Medical ned by the a detached fi signed by t Ş Q

cate has been sig page 2 should b Completed certificate director, Be Certification: To this funeral e Hospital or Attending P 24 hours after death. e Funeral Director; After t After filled in by the within 24 hours a

determined

4 Homicide

(Check only one)

29b. Signature and title of ce

30. Name and address of person

31. Date filed (Month, Day

29a. Certifier

completely

State Registrar

Medical

DHMH 17 Rev 1/2001

Registrar's Si

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Paul Quinn 3.35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arundel Medical Ann Hrundel Conter Anna polis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 TA **Funeral** 1 M 2 D F Days Hours Min 0770471928 579-32-8584 Director VA Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must hand the marked of the property or other traumatic event. 10b. County 10c. City, Town or Location 10a. State Director 10d. Inside City Limits MD Anne Arundel Shady Side 1 ☐ Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4945 Elm Street 20764 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Š 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Library of Congress Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Paul Bernard Quinn Arneta Evelyn Odell 19a. Informant's Name/Relationship (Type, Print)
Elaine Cartwright/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 753 Monarch Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Riverview Cemetery 1
Burial 2
Cremation 3
Removal from State 05/06/2010 Richmond, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, 125 Southern Md Blvd., Owings, MD 20736 21. Signa are of Funeral Service A censee Lisa M. Myuts 3125 Southern Md 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lir Immediate Cause (Final Onset and Death Physician neymonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner eural 2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown 4 ☐ Pregnant a 9 ☐ Unknown After this certificate has been signed by the functional director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) မ 1 Annpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 0063131 2010 Parkwi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arundel Shah Ann medical Center . 21401 Annapolis, cim

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ernesto Rosas April 30, Day 2010 Year 8:45 p M Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Hours Min. Nov. 7ay, Year 923 Comexico 578-30-1188 86 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Rockville Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral with 23a 20852 USA 202 Hardy Place items ? filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces Black, White, etc. ò þ 1 Never Married 2 K Married 2 No Baltimore, Maryland 21215-0036 1 🗷 Yes 2 □ No Specify: Mexican If Yes, Give Year or Dates. 1948-49 Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Banquet Waiter Hotel/Restaurant permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tt</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Rosas Sara Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Knapp Rosas/Wife 202 Hardy Place, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 11 Burial 2 Cremation 3 Removal from State May 15 Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final FAILURG Physician/ ONGES TIVE HEART disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to lor as a consequence of signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 Piko 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 KNo Other: Certificate: To 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Propatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident

Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00057124 511/10 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 10110 Molecular Drive, Rockville, MD 20850

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Montil, Day, Year)

04/30/10

ERNESTO

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Katherine Brett Rettinger 1:00 am April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10803 Hob Nail Court Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Indiana 1 Year 8. Date of Birth **Funeral** Months Days Hours 1272171951 Director 308-60-0464 58 Yrs Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Potomac 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10803 Hob Nail Court 20854 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎗 No Specify: If Yes, Give Year or Dates "natural", 3 - Widowed 4 - Divorced Completed Specify. Caucasian 1 and 2 should be filed within 72 hours of Heaith and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookseller Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leo Edward Zickler Jouce Faith Lippman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Arthur Ivan Rettinger-Spouse 10803 Hob Nail Court, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State injury or c 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 05/02/2010 | Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funer Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
ULOU Immediate Cause (Final Physician/ Widely Metastatic Uterine Sarcoma disease or condition resulting in death) year Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine Due to (dr as a consequence or) cause. Enter Underlying physician and the burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy jo in the past 12 months?
1 \(\sum \) Yes 2 \(\overline{\mathbb{X}} \) No Pregnant at time of death ed by the a detached f g 🗌 Unknown g 🗌 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 X No ☐ Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other 1 🗌 Yes 2 🗓 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 2 P

> State Registrar

Medical

29a. Certifier

only one 29b. Signature3

Annette Bicher,

03

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD.

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

10215 Fernwood Road, Suite 300, Bethesda, Maryland 20817

29d. Date signed (Month, Day, Year)

10

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

argaret Lucino	la S	nowden State of Maryland						gible.	
		1- For State Registrar	Certi	ificate of	Death		R	teg. No. 20	0 555
Physici		Decedent's Name (First, Middle,Last)					Date of Dea Month	Day Year	3. Time of Death
ledical Exami	ner	Margaret L. Snowden 4a. Facility Name (if not institution, give street and number	-1	 14	h City Town or	Location of Deat	April 27, 2	2010 4c. County of D	0846 hrs
		Baltimore Washington Medical Center	,	"	Glen Burnie		"	Anne Arun	
Funeral			ge (In yrs. las	st birthday)	If Under 1 Yea	r If Under 24Hr	s. 8. Date of Bi	rth(MM/DD/YYYY) 9.	
Director		213-32-7658 1_M 2XF		78 Yrs.	Months Day	s Hours Mil	Mar 1		reign 外 硬數以land
= -		Usual Residence of Decedent							
w any		10a. State		own or Location					10d. Inside City Limits
daryland 28a-f show 1 at once.	to	10e. Street and Number	L AIII	Tapori				log. Citizen of What (
th the Maryland 23a or 28a-f sho notified at once.	Director				10f. Zip Code	0.1			ountry?
vith th s 23a e notil		225 Admiral Drive	t Ever in U.S.	. 13. Was	214	OI spanic Origin? (S	pecify Yes or No	USA - 14. Race - Ar	nerican Indian, Black,
leath v r item	Funeral	1 X Never Married 2 Married Armed Forces	? 2 X No			, Mexican, Puert		White, et	
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1	Yes 2 No	specify:		Specify: I	Black
2 hours after "natural",		15. Decedent's Education (Specify only highest grade co				tion (Give kind of . DO NOT use re		16b. Kind of Busine	ss/Industry
36 in 72 han "	plet	Elementary/Secondary (0-12) College (1-4 or 8th 0	5+)		mestic			Private	e Family
215-0036 be filed within 7 tral Hygiene. ked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle,	Maiden Surname)	
215 be file ntal Hy ked o	Be (Eugene Snowden				Emma (Queen		
21 nould bed Mer is mar	ပ	19a. Informant's Name/Relationship (Type, Print)	- 7	!				mber, City or Town, S	tate, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiens Department of Heath and Mental Hygiens and the file matural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Terry Wade (Daughter) 20a. Method of Disposition	Laos ps			field (evern, Mo	
Baltimore, permit. Pages I ar Department of Hee Important: If itel		1 X Burial 2 Cremation 3 Removal from S	late	-	tion (Name of cer er place)	ı	Date	1	,
timent rtant:		4 Donation 5 Other Specify:	Mem		Garde		-4-10		is, Md.
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee		2 N N N N N N N N N	nne and ence es: 1 West	eerfek⊪iySor St. Ar	ns Mort napoli	uary, P.	A. 21401
Physician		Zavry 12 Rees MOS/83 23a. Part I. Enter the disease, or complications that cause	the death. D				_		Approximate Interval
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<u> E</u> xaminer		or condition resulting in death) Due to (or as a cons					, ,	,	
	<u>~</u>	Sequentially list conditions, if any, leading to immediate b. Justo (or as a cons	innunga ats						
	aminer	cause. Enter Underlying Cause							
cuted and transit	Exa	events resulting in death) Last Due to (or as a cons	equence of):						
an an	dical	d. UNPENDED AMENDED							
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Box 68760 e death certificate b the attending physied for use as the bu	sician/Me	23b. Was decedent pregnant in the past 12 months?	:		al death 3	Ectopic pregn	ancy	Month	Day Year
OX 68 eath certifi	/sic	1 Yes 2 V No 9 Unknown 9 Unknown	t time of death	n 5 Oth	er (Specify)				
D. E. the d by the ached	Phy	Part II. Other significant conditions contributing to dea	h but not resi	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
, P.O res that 1 signed b	d b	Diabetes mellitus					1 Yes	s 2 ✓ No 3 F	robably 4 Unknown
rds requi	lete						24a. Was autop		autopsy findings available to completion of cause of
eco he law ate has	Completed							rmed? death	
tal Recian: The	Be C	25. Was case referred to medical				of Death (Check			
Vita hysici this c	TO B	examiner? 1 Yes 2 No Hospital: 1 Inpati		R/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6 0	her:
Division of Vital Records, rate day a Attending Physician: The law requir at a bare death. After this certificate has been sited in by the funeral director, page 2 should the control of	ü	27. Manner of Death 1 Natural 5 Pending Apr 27, 2010	ury 2:	8b. Time of In 0720 hrs		ry at Work?		how injury occurred down stairs	
Sion Attender death cetor:	Certification:	2 Accident Investigation				′es 2 ✓ No	201 1 11 11		David David Marchael Cit
Divi	ij	Suicide Could not be determined (Specify) Cir			, factory, office b	uliaing, etc.	or Town, S		Rural Route Number, City
Hospi 4 hou Funer ely fil		29a. Certifier			ed at the time de	ite and place and			
To the Ho within 24 t To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examiner stated							
E 2 E 8	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Month, Day, Year)
		N-1-			O.C.I	M.E.		April 28, 2010	
11/1		30. Name and address of person who completed cause of			Dame Ct.	Dalki	ID 04004		
JHI		Donna M. Vincenti, MD Assistant Medi			Penn Street,	Baltimore, M	21201 טו		
St Regis	ate	31 Date filed (Month, Day, Year) APR 3 0 2010 32. Registra	ar's Signature	4 /	41				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Charlotte Arlena Stitely Medical Mav 2010 30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1308 Bruceville Road Keymar Carroll 8. Date of Birth (Month, Day, Year) March 16,1927 Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Min. Director 164-22-7998 83 March Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Carroll Keymar 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1308 Bruceville Road 21757 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ō à 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Maryland 21215-0036 "natural", 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Completed Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 6 Laborer Factory other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert. Raymond Johnson Minnie Tressler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl W. Stitely, Jr. /son 36 Bonneau Heights Road Gettysburg, PA 17325 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Final Journey Crematory 5/6/2010 Woodbine, Maryland 21. Sign thre of Funeral Service Licensee any Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition ances 8kulos + 513/10 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last trending physician Physician/Medical Box 68760 as the l IF FEMALE: 1SE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for or Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò pe Division of Vital Records, or Attending Physician: The law requires Completed 1 √es 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 46 2 🖳 1 Tyes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural injury 5 Pending work? 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Rice, M.D555 S. Center Street Westminster, Maryland 21157 State egistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jason Le Andre Sherrill

Physic M≏dical Exam Funeral Director		Jason Le Andr		3				2. Date of De	ath		137	Time of Dea			
M≏dical Exam Funeral			e Sherril	3											
		A. E. 100 B	on Le Andre Sherrill April 22, 2010										•		
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		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of E	Birth (MM/E	DD/YYYYdC	9. Birthpla	ce (State o	or		
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*		Usual Residence of Decedent		1.0 00 =							140				
v any		10a. State 10b. County		10c. City, To	own or Locatio	n						l. Inside Cit			
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Aaryland 28a-f show 1 at once.	岌	10e. Street and Number				10f. Zip Code		· · · · ·	10g. Citiz	en of Wha	at Country?				
5-0036 led within 72 hours after death with the Maryland stygener or other than "matural", or items 23a or 28a-f sho ther than "matural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	1316 Peachtr	ee Court		- 1	2072	01			USA	\				
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after incr	ρ		orced If Yes, Give Ye or Dates:			res 2 X No				Specify:	Bla				
ours		15. Decedent's Education (Spe	cify only highest gra	ade completed) 1		s Usual Occupations of working life.			16b. Ki	ind of Bus	iness/Indus	stry			
72 h	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	during mos	st of working life.	DO 1401 03016	stired)							
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15-0036 Fled within 72 Hygiene. d other than '	[홍	17. Father's Name (First, Middle	, Last)			1	8.Mother's Nan	ne (First, Middle	, Maiden S	Surname)					
215 e file tal H ked	Be	Robert F. She	rrill				Fran	nces Cal	houn						
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	2	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	and Number or	Rural Route No	umber, Cit	v or Town	. State, Zip	Code)			
MD d 2 sho dth and n 27 is	-	Frances Sherri	11/Mother			Oxford A									
e, M 1 and 2 Health item 2	l	20a. Method of Disposition	.II/IDCICI			on (Name of cem		Date	20c. L	ocation - (City or Town	n. State			
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imore, MD 2 Pages 1 and 2 shou ment of Health and N sant: If item 27 is n or other traumatic		4 Donation & XOther Si	pecify: Entomb	ment Fore	est Law	n Cemete	ery 05	5/01/201	0 B	uffal	Lo, Nev	v York	k		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Signature of Fulleral Service	Licensee		22. Na	me and Address		Beall Fu							
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Physician		23a. Part I. Enter the disease, or		caused the death. D							t Ar	proximate			
/Modleal		failure. List only one cause		iurian							Be	etween Ons Death			
≟xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of):							-				
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8760, inficate being physic as the bur	≷	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregnar	ncy 2 Feta	Lidooth 3	Ectopic pregr	ancy		Date of d Month	elivery Day	Ve	ar		
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Box 687 ne death certific the attending p	Si.	1 Yes 2 No 9 Uni	known 9 Unkn	iown	J Otne	r (Specify)			1						
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Division tal or Attendii rs after death.	읥	1 Natural 5 Pend 2 ✓ Accident Inves	ding stigation Apr 22,	2010 1	954 hrs	1 Ye	es 2 🗸 No	Operator 0	· motore	JyOle 3ti	uok a gc	aararan			
/iSi r Att rer da ter da irect irect	≝		d not be	ce of Injury - At home	e, farm, street,	factory, office bu	ilding, etc.	28f. Location		d Number	or Rural Ro	oute Numbe	er, City		
Divi spital or tours afte	ertification:	Odicide ====		Major Road /	Highway			or Town, Ramp from \	State) N/B Rt 2	14 leadin	a to N/B 4	195. Largo	o . MD		
Di the Hospital hin 24 hours a the Funeral	၂ပ	29a. Certifier	hysician: To the be			d at the time det	e and place on	1				. 9			
田名田島	ica S		miner: On the basis									se(s)			
5 E 2 S	Medical		and manner s												
Division To the Hospital or Attention within 24 hours after death To the Funcral Director: completely filled in by the		29b. Signature and title of certifie	71			29c. License					(Month, D	ay, rear)			
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To the within To the comple		Donna M. Vincenti, MI	D Assistant I	se of death (Item 23 Medical Examir		Penn Street,		MD 21201] , , , ,						
Ale		Donna M. Vincenti, MI	D Assistant I		ner 111 F	Penn Street,		MD 21201	1 7						

ORIGINAL

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

SH-10

To the the within: To the

> State Registrar

29b. Signature and title of certifie

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

5 Pending investigation

6 Could not be

determined

eted cause of death (Item 23a) bson

(Type, Print)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

strar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

After

after death.

24 hours a

filled in by

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Medicai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day April 29, 2010 8:59 A. M Agnes D. Shelkofsky 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 8. Date of Birth Jan. 6, Year 912 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1 □ M 2 🗓 K Washington, DC 577-03-3804 98 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Montgomery Chevy Chase MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 USA 3415 Turner Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Georgetown Law School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Walter DeMent Staphania Dengler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 269, Chincoteague Island, VA 23336 Joan S. Kean/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem May 5,2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Heart Disease disease or condition resulting in death) Due to (or as a consequence of): Hyperlipidemia 50 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ∏Yes 2 DoNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov s 23a or 28a-f sh

th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, I' = Medical Event is at a

Item 27 is other tra

permit. Pages 1
Department of H
Important: If Itel
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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner Physician/Medical Be

spital or Attending Physician: The law requires that the death certificate be executed cours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the harial transit þ Completed Certification: To

Division of Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral I

Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **X**No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

29c. License number

D000601

April 29, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank C. Blackburn, MD., 5454 Wisconsin Ave., Suite 675, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year) MAY 03



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death мау 1, 201 0 12:15 рм Physician/ Smith Mary Estelle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Count Chio Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dc Month Pay, 12917 **Funeral** Hours Min. 1 □ M 2 🏝 F 578-01-9414 92 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location with the Maryland 10a State Director 1 Yes X No Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r Funeral IISA 20815 3706 Spring Street items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give SpecifyWhite Completed 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Travel Association Secretary event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever ပ Elsie McMahon Arthur Wright permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11202 Waycross Way, Kensington, MD 20895 19a. Informant's Name/Relationship (Type, Print) Kathleen Kenealy/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition May 2010 20c. Location - City or Town, State 6 NX Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 22 Name and Addyss of For lins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Fever Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Atherosclerotic Heart Disease Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dementia requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of cer

30. Name and address of persor Ajay Reddy,

31. Date filed (Month)

MD

2. Registrar's Signature

ompleted cause of death (ftem 23a) (Type, Print) 3200 Tower Oaks Blyd., Rockville, MD 20852

29d. Date signed (Month, Day, Year) May 2, 2010

D53691

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Year April Physician/ Shepard James 24, Fred 6:30 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctors Community Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 **X** M 2 □ F Day, 89 North Carolina Director 1920 245-16-7432 May 6, Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 Yes 2 □ No Mitchellville Prince Georges Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral United States 3800 Lottsford Vista Road 20721 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc ğ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify. Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fortlift Operator M. Loeb & Company 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 Shepard Kenneth Alberta Hooper Willie 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Tinker Drive; Fort Washington, Maryland 20744 Fredrica Ellen Shepard-Smith 20b. Place of Disposition (Name of cemetery, crematory or other place)
Popular Spring Baptist
May 8,2010

Simpsonville, Carolina 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Swhature of Juneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Fire.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final years Physician/ Cardiac Arrhythmia Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease years Sequentially list conditions Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying sician and burial-transit years Dementia Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician the detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 X No 1 Inpatient 2X ER/Outpatient 3 IDOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed

Rakesh Arora, M.D.; 31. Date filed (Month, Day, Yea MAY 0 3 2010 Registrar

(Check

only one

3 [

29b. Signature and title of certifie

14300 Gallant Fox Lane; Suite 222; Bowie, Maryland 20715 32. Registra & Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

29d. Date signed (Month, Day, Year)

April 29,

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2<u>010</u> Month 25, 3:22 **Physician** Α April la /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Nov. 11, 1 Clinton 5907 Arbroath Drive 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1922 North Carolina **Funeral** 1 □ M 2 🔀 F Yrs 87 Director 241-36-8583 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant if Item 27 is marked other than "natural" or items 23a or 28a-f show 10c. City, Town or Location 10a. State Examiner must be notified at 1 X Yes 2 □ No Clinton Director Prince George's Maryland 10q. Citizen of What Country? 10f, Zip Code 10e Street and Number United States 20735 5907 Arbroath Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🎽 No Baltimore, Maryland 21215-0036 δ 3 2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurses Aide 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyda Whitley Jones Silas Jones ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5097 Arbroath Drive Clinton, Maryland Sarah Boone/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Washington, DC 2010 Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licer 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final vears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day for 5 ☐ Other (specify) the detached 9 TUnknown 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 No 1 ☐Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death.

neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mention and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print)

CR3

State Registrar 31. Date filed (Month, Day, Year) MAY 0 4 2010

32. Registraris Signature

LINTHOUM MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9, 2010 May 1:15 PM Shirley Isabel Sedlak /Medical 4a. Facility Name (If not institution, give street and number)
Oak Crest Retirement
Community 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea, Mar. 6, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🏋 F 1923 Yrs. MD 215-16-7527 87 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show tyFlYes 2 □ No Director York Shrewsbury PΔ 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number r than "natural", or items 23a or 17361 U.S.A. 93 Westview Drive Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married P altimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify. Specify: ۵ White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Small Appliance Elementary/Secondary (0-12) College (1-4or 5+) Manufacture Secretary of the state of th 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Mary Swanner John Kremeyer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 93 Westview Dr., Shrewsbury, PA 17361 Louis A. Sedlak/Husband Department of Health Important: If Item 27 any injury or other troope. 20b. Place of Disposition (Name of Streems Para Tator) (Prance Cown) May 13, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Cemetery Glen Rock, PA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimers **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Z No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes P No redlak Shirles Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes a No Certification: To 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie chealle /2 2010 CRAP, MM

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

CAMP MSN 8800 Walther Blvd, Parkville, MO 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Micheelle G. Harrison

Year

31. Date filed (Month, Day,

05/02/60/50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2010^{Year} Day Month Physician/ 9:30 A. May Margaret Virginia Staley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 8701 C Yellow Springs Road Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Sex 1 ☐ M 2 🗓 F Days Hours Min. 04/30/192 Mary Land Months Yrs 89 **Director** 220-01-2739 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State of Health and Mental Hygiene. I tem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 No Frederick Frederick 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States 8701 C Yellow Springs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give δ Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Ann Suter Coleman Joseph Lidie, Jr. t. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5924 Boyers Mill Rd., New Market, MD 21774 Glen Stalev / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 5/15/2010 Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses (20 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 041 Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examin<u>e</u>r Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months?
1 Yes 2 No for Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ANTHRITIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 ☐ No 2 1 NO certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes within 24 hours after death,

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying use Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title و تعلیلا

State Registrar

DHMH 17 Rev 7/2009

BAUGHMAU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

MENOCIM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 1555 | State of Maryland / Department of Health and Mental Hygiene

heryl Ann Sage		State of Maryland	l / Departme <i>Certifica</i>			and Mer	ntal Hyg		a Na	
Physicia	an/	1. Decedent's Name (First, Middle,Last)						Date of Death Month	g. No. n Day Year	3. Time of Death
ledical Exami	ner	Sheryl Ann Sager	×	- 1.				May 6, 201	0	2120 hrs
		4a. Facility Name (if not institution, give street and number Carroll Hospital Center	er)	4	b. City, Town Westmin		of Death		4c. County of Dea Carroll	tn
Funeral			ige (In yrs. last birth	nday)	If Under 1				irthplace (State or	
Director		213-88-4977 _{1 M 2} F F	42	Yrs.	Months [ays Hour	S AVIIII.	12/11		ountry) MD
á		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	or Location	on					10d. Inside City Limits
nd thow a	_	MD Carroll	Tan	eyt	own					1 XYes 2 No
daryland 28a-f show any 1 at once.	Director	10e. Street and Number			10f. Zip Cod	e		10	g. Citizen of What Co	untry?
the N 3a or		40 E. Baltimore Stree	et		217	87			USA	
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force:	s?		Decedent of es, specify Cu			ify Yes or No- can, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
ter des		1 Yes 3 Widowed 4 X Divorced If Yes, Give Year	2 X No	1	Specify: W	hite				
ours af atural Kamin	d by	15. Decedent's Education (Specify only highest grade of	ompleted) 16a. D	ed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						/Industry
16 n 72 h nan "n ical E	ompleted	Elementary/Secondary (0-12) College (1-4 o	r 5+)		ied r				health	
d withi	mo	17. Father's Name (First, Middle, Last)	, ce.	LCII	i i eu i				aiden Surname)	
215 be file ntal Hy rked o	Be	Raymond Ruggles, Sr.						Aski		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Name/Relationship (Type, Print)								e, Zip Code) 21102
and 2 sealth a tem 27		Patricia A. Ruggles,	20b. Place of						20c. Location - City o	
DOFE ages 1 nt of H t: If it		1 X Burial 2 Cremation 3 Removal from S			er place) ad Cen	neter	v 5/1	0/201	0 Hampst	ead. MD
altin mit. P. partme portan ury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	M00741				T		neral Ho	
E P P E	V. J	Handa L Lemmer	,	93	84 S.	Main	st.,	Hamp	stead, M	
Physician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Combi	ed the death. Do not ned effec	enter the	e mode of dyi of etha	$rac{1}{2}$ anol,	cardiac or re dipher	spiratory arres 1hydr am	st, shock, or heart	Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a. Citalopr Due to (or as a con	am OXVCC	done	alpi	razola early	m, & c	xymorp	hone	Death
		Sequentially list conditions, b		N. 1915	orene art. n	SUBSCIEV :		- Section (Section)		
	miner	if any, leading to immediate Due to (or as a concause. Enter Underlying Cause	sequence of);							
d sit	Exan	(Disease or injury that initiated events resulting in death) Last	sequence of):							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit	edical	d. X UNPENDED AMENDED				20/E 2	00.1/	v mm		
60, ate be ex hysician e burial	Medi		,27,28a-1	. , Pe	er ME (3905 7	.22.10	TT	23d. Date of deliver	<u> </u>
OX 6876 eath certificate attending phy for use as the t	ian/I	23b. Was decedent pregnant in the past 12 months?	2 at time of death	=		3 Ectopi	ic pregnancy	,		Day Year
Box e death c the atter ed for us	hysician/M	1 Yes 2 No 9 V Unknown 9 Unknown	5	Oth	er (Specify)					
O. Dat the set by the etacher	ᄱᅵ	Part II. Other significant conditions contributing to dea	ath but not resulting	in the ur	nderlying caus	se given in P	art I.		acco use contribute to	
S, P.C juires that an signed b	ed by									bably 4 Unknown
cords, aw requi has been a	ompleted							24a. Was ar autopsy perform	y prior to	completion of cause of
tal Reco	5				20.5		/01 1 1	1 ✓ Yes 2		es 2 No
/ital ysician: his certifi director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpat	ient 2 🗸 ER/Out	tpatient		Other			esidence 6 Othe	oc.
of \ing Phy		27. Manner of Death 28a. Date of In	jury 28b. T	ime of In	jury 28c. I	njury at Worl			ow injury occurred	2
ion ttendii death tor: /	atio	Natural 5 Pending Pending Investigation 5/6/10	8:2	5 pm		Yes 2X	No		took drug	
Division spital or Attent hours after death meral Director:	ertification:	Suicide Could not be determined	Injury - At home, far residence		, factory, offic	e building, e	tc. 28	f. Location (Stror Town, Sta	reet and Number of Rate) 552 Wash	ural Route Number, City Lngton Rd
Diving the Hospital or within 24 hours after To the Funeral Diving completely filled in	ပ	29a. Certifier	my knowledge, deat	th occurre	ed at the time	date and pla			ster, MD	ted.
To the Ho within 24 To the Fu completely	edical	one) 1 Certifying Physician: To the best of its one) 2 Medical Examiner: On the basis of examiner stated	amination and/or in							
	Me	29b. Signature and title of certifier		_		ense number		- 1.	29d. Date signed (Mo	onth, Day, Year)
WJL					0.0	C.M.E.			May 7, 2010	
		 Name and address of person who completed cause of Donna M. Vincenti, MD Assistant Med 		111	Penn Stre	et, Baltim	ore, MD 2	21201		
St	ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	,						
Regist	rar	MAY 1 2 2010 / Perse	un d.	Do	Kel					

SCHUMM, MADELINE # 465902

Physician

/Medical

Examiner

Funeral

Director

· Items 23a or 28a-f show increment be notified at

Registrar DHMH 17 Rev 1/2001

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Usual Residence of Decedent

130 22 8379

10e. Street and Number

10a. State

Madeline

4a. Facility Name (If not institution, give street and number)

6. Sex

CIVISTA MEDICAL

10b. County

7110 Dower House Road

Maryland | Prince George's

Schumm

1□ M 200 F

ENTER

10c. City, Town or Location

7. Age (In yrs.

95

23a	ल	/110 Dower Hou	se koad		20112			OIL	Lea Die	1000			
Taryland 21215-0036 2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "natural", or Items 23a raumatic event, it with dical Examinations.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	8	Race - Americal Rack, White, cify:	etc.			
ours ral";	2	3 X Widowed 4 □ Divorced	Year or Dates:		- X			Оре	ony.	White			
15-0	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	((ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of wor	king	16b. Kind of	f Business/In	dustry			
withi iene.	Ē	Elementary/Secondary (0-12) 9th	College (1-4or 5+)	Sai	les Clerk			Mac	cys				
d Silled Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surn	name)				
d be ental	9	Frank Wacht	el			Martha	Stegner						
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours after death v partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or items 23a y injury or other traumatic event, it. M. dical Everi in r. ust		19a. Informant's Name/Relationship (Marlene Pace (Daugh		19b. N	lailing Address (Street . 7110 Dower Hou	and Number or Ru use Road, U	iral Route Numbe Ipper Marl	Route Number, City or Town, State, Zip Code) per Marlboro, MD 20772					
MOCe, Pages 1 an nent of Herent of Herent of Herent of Herent of the net of t		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery,	isposition (Name of crematory or other place		Date 2010		on - City or To				
ti Pa t. Pa rtmer rtant:	-	4 □ Donation 5 □ Other (Specify	·	surre	ction Cemeter				n, Mary	Old Alexandria			
Baltimol permit. Pages Department of important: If is any Injury or or		21. Signature of Funeral Service Licer	morbie	١	Ferry Road, (none, n	IC 0033	OIU Alexandi ia			
Physician		23a. Part Enter the disease, or com show, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the death one cause on each line.	. (ng, such as cardiad	or respiratory a			Approximate Interval Between Onset and Death			
/Medical Examiner		resulting in death)	noss	Q	Desired								
	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of)	, 4								
cuted	Examiner	Cause (Disease or injury that initiated events	C										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. If or death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death	3 Ectopic pregnanc 5 Other (specify)	у		23d.	Date of delive Month	very Day Year			
P.O. that the de ed by the detached		Part II. Other significant conditions of	ontributing to death but not resu	23e. Did t	d tobacco use contribute to the cause of death?								
ords,	ed by			1 🗆 '	1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown								
Division of Vital Records, or Attending Physician: The law requires the reach Director: After this certificate has been signed in by the funeral director, page 2 should be detailed.	Completed			24a. Was autop perfo 1 □Yes	topsy prior to completion of cause of death?								
'ita	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o	ne)					
hysic his o		1 Yes 2 XNo	Hospital: 1 Inpatient 2	ER/Outp		4 🗀 Nursing r	lome 5 ☐ Resi	dence 6 🗆	Other (Spec	rify)			
ion o ending Pl ath r: After ti	ation: To	27. Manner of Death 1	1 1	28b. Tir Inji	ıry Wor	ryat k? Yes 2 □ No	28d. Describe	how injury oc	curred				
Divis	Sertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farn	n, street, factory, office	<u> </u>	28f. Location (City or To		umber or Ru	ral Route Number,			
e Hospit: 124 hours e Funera iletely fille	Medical Certific	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, tion and	death occurred at the ti for investigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)			
To th within To th comp	Me	29b. Signature and title of certifier	wath	~	29c. Licens	se number	729	29d. Date si	gned (Mont)	, Day, Year)			
		30. Name and advess if person who	completed cause of death (Item	23a) (T	ype, Print)	- 11	, *,		MAR	ZYLAND			
936		GEORGEH WATHE	NMD 11345	PEM	brooke 5Q	UARE #1	03 WA	LDORG	120	603			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Months

10f. Zip Code

20772

Upper Marlboro

2. Date of Death

8. Date of Birth (Month, Day, Year) Feb 8, 1915

APRIL 30 2010 8:45

4c. County of Death

10g. Citizen of What Country?

United States

CHARI

Year

3. Time of Death

Birthplace (State or Foreign Country)
 New York

10d. Inside City Limits

1 ☐ Yes 2 XXIo

ORIGINAL

Dever S. pars

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Henry George Singer Sr. 3:00P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Braddock Hgts. Vindohona Nursing Home 8. Date of Birth Morth, Bay Year 7 28 1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 150-22-2435 1 🔀 M 2 🗆 F NY Director 87 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director Middletown Frederick 1 🗆 Yes 2 🏝 No MD 10f. Zip Code 21769 10e. Street and Number 10g. Citizen of What Country? Funeral 7106 Flint Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? 1942 Yes $2 \square$ No 1946 If Yes, Give 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 1946 Specify: White "natural" Completed 3 Widowed 4x Divorced Year or Dates nt of Health and Mental Hygiene.
It if item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) municipal Elementary/Seconday (0-12) College (1-4 or 5+) government fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cecelia Callahan Henry Adolph Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $7106 \;\; Flint \;\; Ct., \;\; Middletown, \;\; MD \qquad 21769$ Nancy Franco (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State b. Place of Disposition (vame of Armitishing telephore New Young 1 8/12/2010 Arlington, VA 1 Burial 2 ☐ Cremation ∧3 ☐ Removal from State Department of Important: If any injury or Donatic n 5 ☐ Other (S Si ure of unera Service Li ²Tonald B. Facilinompson Funeral Home POB 18. Middletown. ter the disease, or compli heart failure. List only one hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate ock, or, Interval Between Onset and Death Immediate Cause (Final ROSTATE Physician CARCINOLA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 10587 2010 0 30 HOPPICE OF FREDERICK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIRECTOR FREDERICK MEDICA GTIVA 516 TRAIL (JEO ACE

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

APR

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) May 3, **Physician** 2010 12:33 A M Mozell Lorie Scholl /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 513 Priscilla Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 5, 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Y923 1 ☐ M 2 ☐ F Yrs. 215-14-3213 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural; or Items 23a or 28a-f show traumatic event, the Medical Examinar must be retified at 1 XYes 2 No Director Maryland | Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 513 Priscilla Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if fiem 27 is marked other than "natural; or Iten any injury or other traumatic event. Its Medical Examinan 1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lessie Childress Eli Childress 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 N. Kaywood Drive, Salisbury, MD 21804 Robert Scholl/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/6/2010 Beulah, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 21. Signature of Fureral Service Lic Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that is back, or heart failure. List only one cause on Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 0 No 1 TYes or Attending Physician: after death. Director: After this certitica the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Nih 047094 5/3/10 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 STUS BURY 3- DIVISION NATESAN 1415 5hece

DHMH 17 Rev 1/2001

State Registrar 2. Registrar's Signature

			For State	State	of Man	yland / De		t of Hea		d Men					
_			Registrar 1. Decedent's Name (First, Middle, L							2. [Reg Date of Death	. No.	3. Time		
	Physicia	an		t Duane	Steve	ens					Month lay 2		Year I N	1839 M	
¥	/Medic		4a. Facility Name (If not institution, g	<u> </u>		CITS	4b. City.	Town, or Loca	ation of De		la y Z	4c. County o		1000	
,	Examin	er	Harford Memor				, , ,	Havre			Harford				
	Funeral			Sex		fn yrs. last birtho			Under 24 F			9. Birthplace (State or Foreign			
	Director		305-34-9695	1 □ M 2 💢 F	7!	5 Yr	Months.	Days Ho	ours M	Ju	Month, Day, Y	°°°1934	In	diana	
Н	D		Usual Residence of Decedent												
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	hours alter death with the Maryland turet; or ttems 23a or 28a-f ehow al Examinar must be notified at	Funeral Director	104 Remington Ro						1904						
	er de Item	une	11. Marital Status	12. Was Dec	orces?	er in U.S.	13. Was Dece If Yes, spe	dent of Hispar cify Cuban, M	nic Origin? Iexican, Pu	? (Specify uerto Rica	Yes or No- n, etc.)		- Amend , White,	an Indian, etc.	
5	rs att	by F	1 ☐ Never Married 2 🖔 Married 3 ☐ Widowed 4 ☐ Divorced	1 (X) Yes 11 Yes, G Year or I	2 No		1 🗆 Yes	2⊠ No Sp	pecify:			Specify:	Wł	nite	
21213-0038	hou		15. Decedent's		Ja103.	16a. D	ecedent's Usu	al Occupation			16	b. Kind of Bus	iness/In	dustry	
Ò	in 72	ojet	(Specify only highest g	grade completed,		(()	ive kind of wo	rk done during se retired)	g most of	working				,	
7	with iene	Completed	Elementary/Secondary (0-12)	TWO Y	ears	Fi	rst Cl	ass Pe	tty 0	Offic	er l	Jnited	Stat	es Navy	
0	i Hyg othe	BeC	17. Father's Name (First, Middle, Lat	st)							st, Middle, Ma	iden Sumame)		
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Mary	should have	.	19a. Informant's Name/Relationship								ute Number, C				
Σ	alth a		Arline B. Stever	15 (wife)) 104	Remin	gton R	oad,	Port	Depos	it, Mar	ylar	nd 21904	
ē	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If teem 27 is marked other then "neturel; or items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.	1	20a. Method of Disposition		- 1	20b. Place of D cemetery,	crematory or	ther place)	Ī	Date	1.	vest Ch			
Ĕ	Page nent of iny or		1 ☐ Burial 2 🂢 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	R.A.Fer	ris &	Co. In	c 🕴 05	5/04/	10			Ívania	
Бант	permit. Departri Imports eny inju		21. Signature of Funeral Service Lic	ensee		/	22. Name a	nd Address of	Facility	£ 50	n Fune	ral Hom	e. I	Ρ.Α.	
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	/Medical		resulting in death)	_		consequence of)		301-7					-		
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õ	ing p	40	IF FEMALE:												
Š	leath certific attending p I for use es i	Physician/M	23b. Was decedent pregnant in the past 12 months?		birth 2 (Fetal death	3 ☐Ectopic p					23d. Date Mon		ery Day Year	
3	the deay the a	sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Preg 9□ Unkr		ne of death	5 Other (s	pecify)						,	
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d)	e law	Completed								_	24a. Was an autopsy performe	i pr	lere auto rior to co eath?	psy findings available mpletion of cause of	
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VII	Physician: The law this certiticate hes braidirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	,			Other			heck only one)				
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S	Attending ir death. ector: Atter by the fune	ica	3 Suicide 6 Could not	be Zee Pine	e of Injury	- At home, farm				28f.	Location (Stre	et and Numbe	r or Run	al Route Number,	
	al or Attend after death I Director: / d in by the f	Certification:	4 Homicide determine	build	ding, etc. ((Specity)	, 31, 551, 145151	y, onlos			City or Town,				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Discourse Alter this certific completely tilled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To th	e best of r	my knowledge, o	leath occurred	at the time, d	date and pl	lace, and	due to the cau	se(s) and man	iner as s	tated.	
	24 h 24 h Fur	edicai	(Check only 2 Medical Ex one)	aminer: On the	basis of ex	xamination and/	or investigation	n, in my opinio	n, death o	occurred a	t the time, date	e and place, a	nd due to	o the cause(s)	
	vithin To th	Me	29b. Signature and title of certifier		7		29	c. License nur	mber		290	d. Date signed	(Month,	Day, Year)	
			F/ 7.				1	2001	691	18	4	5/3/1	0		
7.	+ 11/A		30. Name and address of person wh	no completed cau	se of deat	th (Item 23a) (Tr	pe_Print)		41	11		12/1			
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×	Sta	te	31. Date filed (Month, Day, Year)		Registrar's	s Signature									
c	Registr	ar	MAY 03 2010	Denve	3 1.	par									

DHMH 17 Rev 1/2001

STEVENS, HERBERT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#10C per FH State of Maryla State 4/30/10 CMH AACO HEALIH DEPT. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26^{Day}2010^{Year} Physician/ April Merilyn A. Preston Taylor 11:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care lownson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 DEF Months Days Hours Min. Oct. 22 D.C. 579-52-5042 75 Yrs. 1934 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Gleb Glen Burnie 1 X Yes 2 No Maryland Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 125 Allen Road 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Black Specify: 3 Divorced 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry A.A. Co. Dept. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Uperator of College (1-4 or 5+) Elementary/Seconday (0-12) Public Works 12th Senior Waste Water Plant 3yrs permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Mason Alsop Martha Chinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott L. Preston (Daughter 125 Allen Rd. Glen Burnie, Md. 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 4/29/10 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) wm. Reese & Sons Mortuary, F 821 West St. Annapolis, Md. Signature of Funeral Service Licenses MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SOUAMOUS CELL LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?

1 Yes 2 No Month Year Day ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMPHYSEMA 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ADENOLARCINOMA OF WING 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D64395 APRIL 27, 2010

Registrar

State

32. Registrar's Signature

6701 N CHARLES ST, SUITE 4105 BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Pring

M um

Registrar's Signature

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Day 2010 April 27, Mollie Virginia Templeton 5:43 Αм 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/23/1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 94 yrs. Social Security Number 224-01-3146 6 Sex Days 1 □ M 2 🕶 E Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 Hunt Meadow Drive 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: White 1 ☐ Yes 2 🛂 No þ Specify: 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Templeton Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Lee Franklin Besse Mae Robinson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pattie Lafranchise - Daughter 1611 Hunt Meadow Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/3/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) distant 1 schemic bourd Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bowd obstruction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown acute venal 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 □No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event if a Modical Examinational Denotified at

Physician

/Medical

Examiner

attending physician and for use as the burial-trar

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signed by t

has been si e 2 should t

After this certification

page certificate

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. or Attending

To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

To the Funeral Director: Aft

31. Date filed (Month, Day, Year) APR 2 9 2010

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

determined



2001

State

Registrar

1 Acrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical

29c. License number

46052

Parkway annapolo

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 25^{Day} 20°10 Richard Ryde Tracy, 3:21 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 4012 Caribon St. Mitchellville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Hours 0872471941 Washington, D.C 68 **Director** 220-38-2148 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 28a-f Mitchellville 1 🗌 Yes 2 🛛 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 4012 Caribon Street 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14 Bace - American Indian. 1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates.1960-64 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Mediconce. Elementary/Seconday (0-12) College (1-4 or 5+) Building Engineer Housing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Sullivan Frank Tracy Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 Caribon Street, Mitchellville, MD 20721 Mary Kathleen Tracy/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4/30/2010 MD Veterans Cemetery Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fun 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ nutt disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ ō in the past 12 months? Month Year Day Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 3/No Yes Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ၉ 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death.
I Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 1 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ASTAVA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 29, Day 2010 Betty Joan Tilley 5:30 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 1/2/1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2√□F Months Days Hours 551-20-4686 89 Missouri Usual Residence of Decedent 10a. State Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Anné Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e. Street and Number 1315 River Crescent Drive 10f. Zip Code 10g. Citizen of What Country? USA 21401 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. □Yes 2 No 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Writer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brown Schoenheit Alma Sampson 19a. Informant's Name/Relationship (Type. Print) William Tilley - Husband 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 1315 River Crescent Dr, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/3/2010 Baltimore Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Mysein T. Vilobert 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final heart failure exacerbation disease or condition resulting in death) Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a, Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 **M** No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

event, the Medical Exercitor must be notified at

"natural", or items 23a or

Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, Inc. Magnee.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Funeral Director

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Examine Physician/Medical Completed by Be Certification: To Medical

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sician and burial-transit phys the t attending p for use as t s been signed by the should be detached page 2 director, filled in by the funeral thin 24 hours a

Division of Vital Records, P.O. Box 68760,

completely within 7 è

State Registrar

29b. Signature and title of certifie OSRYCZ ML

6 ☐ Could not be

3 Suicide

29a. Certifier

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ense Hmy, Crofton MD 21114

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2275E 0

31. Date filed (Month, Day, Year) MAY 03

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Baltimore,	t. Page tment o tant: If tant: If		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	oto cen	Veters Vetera	sition (Name of patory or other pla ans Ceme	tery (05/06	·	Ch	ocation - City or e1tenhai	m, MD		
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20	eath certificate be executed attending physician and for use as the bunial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or c. Dema	as a consequer TOP as a consequer	nce of):									
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	. 1		30. Name and address of person who	completed cause of	death (Item 2:	(<i>D</i>) 3a) (Type, Pr	int)	02			0	5/03/	2010		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28 Physician/ Day 11:56am Claire Louis-Charles Thrasybule 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Derwood Montgomery 16105 Carnegie Avenue 8. Date of Birth (Month, Day, Ye March 21 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 🗆 M 2 🗓 F Min. Months Hours Director 220-88-8912 92 Haiti Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 20855 U.S.A. 16105 Carnegie Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmission. Elementary/Seconday (0-12) College (1-4 or 5+) Nurs<u>e</u> Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Louis-Charles Maria Vital 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Finale Terrace, Silver Spring, Maryland 20901 Wesner Thrasybule - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State 05/07/2010 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1800 New Hampshire Ave., Silver Spring, MD 20904 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Interval Between Onset and Death
75 years Immediate Cause (Final Physician/ Demontia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the burial-transit Cause (Disease or impury that initiated events certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 🗆 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending M 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Sign

MD,

2010

Wendy Wong, 31. Date filed (Month, Day, Year)

MAY 03

D0062590

2101 Medical Park Drive: Silver Spring, Maryland 20902

April 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month - 30 - 2010 Physician/ George lears Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shock-Trauma Baltimore Center umms Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 X M 2 □ F Months Days Hours New Jersey 140-16-8676 86 **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location notified at Director Carroll County Hampstead Maryland 28a-f 1 ☐ Yes 2 X No 10f. Zip Code 21074 10g. Citizen of What Country? 10e Street and Number ö the Medical Examiner must be 23a Funeral 4549 Lower Beckleysville Road United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian. Armed Forces?

1 Xyes 2 No WW II
If Yes, Giv 943-1946
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired).
department chief 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 I of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) 12 College (1-4 or 5+) telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leo J. Tears Hannah Narobetski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Northbrook Drive Hampstead, Maryland 21074 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Margie T. Farmer / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place.
Hampstead Cemetery 1 X Burial 2 Cremation 3 Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home Hampstead, Maryland 21074 934 South Main Street M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Subwachnuld Ph_sician/ disease or condition resulting in death) nemorrhus Medical Due to (or as a consequence of): Examiner rehich motor Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a nor sequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER and that initiated events Due to (or as a consequence of): resulting in death) Last ing physician a Physician/Medical or Attending Physician: The law requires that the death certificate be the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Yes 2 g To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an Coronery autonsy performed?

Yes 2 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Natural Vehicle Acoldent Motor 2 Accident 04-27-2010 13:10 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Posts 482 and Pamber Dr., Hampstead, MD Street Medical 29a. Certifier 🗔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated University of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number WJZ 24476 04-30-2010 20:15 MI 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St am 1 mmons 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thompson, Sr. Apyri 29, 2010 11:35 A Jack Ivan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlotte Hall St. Mary's Charlotte Hall Nursing Home 8. Date of Birth (Month, Day, Xear) May 9, 1931 5. Social Security Numbe 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** California 553 42 1558 Director 78 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🗒 No Temple Hills Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 4304 Henderson Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces YVY Yes 2 No 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. White Year or Dates. Korean Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Firefighter DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ivan Thompson Helen Fast 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen R. Thompson (Wife) 4304 Henderson Road, Temple Hills, MD 20748 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Clinton, Maryland Lee Crematory May 1, 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Low Funeral Home, Inc 5633 Old Alexandria 21. Signature of Funeral Service Licen: M01555 Ferry Road, CLinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) consequence of Examiner Sequentially list conditions, if any leading to immediate Physician/Medical Examiner Due to lor as a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) g Unknown Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 2 🗌 No Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 \square Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 5 Pending 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor Leena Rao odali 101 Hospital Road Prince Frederick,

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Day 26 20°10 8:00 A M Eleanor Weston 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Annapolis 409 Oaklawn Avenue 8. Date of Birth (Month, Day May 12 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Days Months Maryland 1 M 2 K F 1924 85 216-36-3602 Vrs Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 □Yes 2 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 409 Oaklawn Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 27 No Specify: Specify: Black 3℃ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Family Domestic 8th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgianna Smith Jesse Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Md. 21401 Dimitri Weston Sr(Grandson) 409 Oaklawn Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-4-10 Crownsville, Md. Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) Williame Rockets of Reili Sons Mortuary, F.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Lavry B, Been MOO483 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (almount UNG disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter process of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ANo 1 ☐ Yes 2 Do 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner or Attending Physician; The law requires that the death certificate be executed Box 68760. P.O. I Division of Vital Records, certificate

physician and s the burial-tran attending pl signed by the a ficate has been siç r, page 2 should b After this certification funeral director, p the Funeral Director: Af Hospital

Physician

Examiner

Director

Funeral

Completed by

Be

ဂ္

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

4 Homicide

(Check only

29a, Certifier

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Examiner must be notified at

permit. Pages Department o Important: If i any injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

/Medical

Registrar

To the Iv within 24 To the F

29b. Signature a

and manner stated.

CATERO 30D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Menth, Day, Year)

30. Name and address of person w

31. Date filed (Month, Day, Year) 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month May Marta Iris Waters 2010 12:37a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton 41 Cimarron Circle 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** (Month, Day) Days .^{Year)} 19<u>58</u> Min. Puerto Rico 1 □ M 2 🗓 F 52 Director 584-02-4057 Usual Residence of Decedent 10d. Inside City Limits than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State with the Maryland Examiner must be notified at Director 1 Yes 2 X No E1kton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 41 Cimarron Circle permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 □ No Specify Puerto Rican Maryland 21215-0036 Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Pre-School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marta Ortiz Miguel Falcon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Cimarron Circle Elkton, MD 21921 William G. Waters Jr./ husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/5/2010 1 Burial 2 X Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
T. Foard and
59 E. Main St. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Immediate Cause (Final to bor Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Year 1 ☐ Yes 2 y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Other: 2 X(No 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Within 2 To the F

State Registrar (Check

only one)

29b. Signature and title of certifier

led (Month, Day, Year)

MAY 0 4 2016

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dimonson

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2018 Elfrieda M. Walter 3:59 Рм Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Rowie Prince George's Heartfields 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 0272571913 1 □ M 2 🛣 F "New Jersey 97 Director 138-05-5937 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner most because once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bowie MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 USA 12808 Kendale Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Credit Bureau Legal Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elfrieda Mallen George Brickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12808 Kendale Lane, Bowie, MD 20715 Elfrieda L. Harris/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Barnabas Ch. Cem. 05/03/2010 Upper Marlboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of un al Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of rons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ise on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death signed by the a ld be detached for Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 s certificate has autopsy performed death? 1 Yes 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death) 6Year Month 5 +:14A M Physician/ Wilber Mildred Euerle Medical give street and 4a. Facility Name (if not institution, Examiner 4c. County of Death i comi c 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 F 7-19-1922 Connecticut Director 049-03-6520 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any niury or other traumatic event, the Medical Examiner must be notified at any niury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. Cíty, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Salisbury MD Wicomico 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 335 Hampshire Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Euerle** Marshall Frances Fred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Hampshire Road, Salisbury, Maryland 21801 Donald Wilber - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5-4-2010 Delmar, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complication Immediate Cause (Final Onset and Death Physician/ ANCREA TIC CARCINDAM disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed Yes 4 certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 6 Oother (Specify) HOSPICIZ ဂ္ To the Hospina. Within 24 hours after death.

To the Funeral Director: After this of 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	-				ntal Hyg	jiene		
			1 - State Registrar AMEND#29dperM		V,MbCo	Certificate	of Dea	th	R	eg. No. 2	0 ! 0	15580
	Physicia /Medic		1. Decedent's Name <i>(First, Middl</i> e, La L	ast) AZARUS JAM	ES WILLI	AMS			Date of Deat Month APR	Day	Year 10	3. Time of Death 2:45 A
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or								20112 21	
' مر			NATIONAL NAVAL	MEDICAL CE	NTER		BETHES				MONTGO	MERY
	Funeral Director			Sex 7. Age 12 M 2 ☐ F	e (In yrs. last birti	rs. If Under 1 Months I	Year If Ur Days Hou	nder 24 Hrs. 8. urs Min. Ap	Date of Birth (Month, Day ril 8,	Year) 2010	9. Birthp Coun Mary	
	ם,		Usual Residence of Decedent									
	show	<u>_</u>	10a. State 10b. County		10c. City, Town	or Location					11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	Maryland Montgo	mery	Silve	r Spring						
	vith th		10e. Street and Number			10f. Zip C			1		of What Coun	•
	sath v	eral	3537 Sheffield	Manor Terr				- Ori-ing (Consile	Vac or No		ed Sta	
136	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, it in clical Evan, nor must be notified as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:		If Yes, specify	y Cuban, Me	c Origin? (Specify xican, Puerto Rica ecify:	n, etc.)	Sne	Race - Americ Black, White, e cify:	etc.
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yland	should be tand Mental s marked o umatic eve	10	Jeshannan Willi	ams				Elizabet	h Mc	Coy		
Mar	2 should be filed w n and Mental Hygie 'is marked other t raumatic event, In	ľ	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (5	Street and N	umber or Rural R	oute Numbe	r, City or Tov	vn, State, Zip	Code) 20904
e, _	and and marker and 27 m 27 ner tr		Elizabth William	s/ Mother		7 Sheffi						
9	jes 1 Tof H if Itel		20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from State	20b. Place of cemeter)	Disposition (Name , crematory or othe	of er place)	Date		20c. Locatio	n - City or To	wn, State
Ē	Pag tmeni tant: lury o		4 □ Donation 5 □ Other (Speci		Ft. Li	ncoln Cre					wood,	MD
Baitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		21. Signature of Funeral Service Lice	nsee	1101413	22. Name and		^{facility} Simp .e Pike,	le Tr Rockv		MD 208	352
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	/Medical		resulting in death)	a	a consequence o							
	Examiner		Sequentially list conditions	b								
	p it 9d	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):									
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×	certif nding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					224	Date of delive	
O. Box	w requires that the death certifi been signed by the attending is should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown								23d. Date of delivery Month Day Year	
7.	that the ed by detac	문	Part II. Other significant conditions	contributing to death be	ut not resulting in	the underlying cau	se given in F	Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
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VITAI	ding Phystclan: The lav h. After this certificate has funeral director, page 2 3	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Place of Death (C	heck only on	re)		
5	Phys	은	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		patient 3 DOA	41	Nursing Home				y)
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VISION	deat deat ctor: y the	fica	3 Suicide 6 Could not b	e 200 Place of Inju	ırv - At home, far	m, street, factory, o			Location (S	treet and Nu	mber or Rura	l Route Number,
2	af or / after I Dire d in b	Certification: To	4 ☐ Homicide determined	building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,			City or Town	n, State)		,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 ☐ Certifying P (Check only one)	hysician: To the best ominer: On the basis of and manner sta	examination and	death occurred at d/or investigation, in	the time, da n my opinion	ite and place, and , death occurred a	due to the cat the time, c	ause(s) and late and plac	I manner as s ce, and due to	tated. the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	The trial life of the		29c. I	License numl	ber	2	9d. Date sig	ined (Month,	Day, Year)
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,	יז		30. Name and address of person who	completed cause of d	eath (Item 23a) (CIONAL NA	VAL M	EDICAL	CENTI	ER
			JASON D. HIGGINS	ON LCDR M	C USN			HESDA MI				
	Sta		31. Date filed (Month, Day, Year)	32. Registra		a Pal						
	Registr	ar	MAY 03 201	U Sknown	p. 19	all !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4/28/2010 Shirley Yvonne Wiser 1650 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Months Davs Hours (Month, Day, Year) 3/4/1938 Director 232-62-5806 72 Franklin Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Riverdale 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5900 67th Avenue 20737 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of Horace Lambert Edna Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health ar t: If item 27 is 7 or other trau Riverdale MD 20737 Elton Wiser, Jr. / Husband 5900 67th Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 5/6/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Fatal Onset and Death Physician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? XNo 1 Tes Yes To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 **X**No Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

MAY 0 4 2010

person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		State	ot Ma		epartment o Certificate d			/lental Hy	giene (Reg. No.	JIU	5583											
	Physici	ion	1. Decedent's Name (First,	Middle, La	ist)						2. Date of De Month	eath	Year	3. Time of Death											
-	/Medi				MILDRED GRACE WADE					April	28 2010 1:		1:30 A M												
	Examir	ner	4a. Facility Name (If not ins Record Stre					4b. City, Tow		ocation of Death.			nty of Death $ederic$												
	Funeral Director		5. Social Security Number 051-16-6848	6. 8	Sex 1 □ M 2 □ F		e (In yrs. last birth	(ay) If Under 1 Ye	ar	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug • 1	th av. Year) 6, 191	9. Birth	place (State or Foreign ntry) York											
	and		Usual Residence of Deceder 10a. State 10b. C				10c. City, Town of	r Location						10d. Inside City Limits											
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is directly from the reachest permitted at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 【X〕 Widowed 4 □ Div		12. Was De Armed I 1 ☐ Yes If Yes, 0 Year or	orces? 2 X II	Everin U.S.	13. Was Decedent If Yes, specify (1 ☐ Yes 2 ☐		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, cify: Whi	etc.											
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.O. Box	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit			ıysician/M	ysician/N	ıysician/M	ıysician/M	ysician/M	ysician/M	nysician/M	ysician/M	Physician/M	nysician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes → 2 ☐ No 9 ☐ Unknown	nt	1 🗌 Live	birth gnant at	of pregnancy 2 □ Fetal death t time of death	3 ☐ Ectopic pregn 5 ☐ Other (specify					Date of deliv Month	rery Day Year
ъ, С	res that igned b be deta	by Pł	Part II. Other significant co	nditions o	contributing to	death bu	ut not resulting in th	e underlying cause	given	in Part I.	23e. Did t	obacco use c	ontribute to t	he cause of death?											
ord	w require been signatures	ted t	Hyperter	Me	n H	7 ₁ 12	Muga	dism			1 🗆 '	Yes 22 No	3 ☐ Pro	bably 4 ☐ Unknown											
ec	e faw r has be je 2 sh	Completed	Kistory	af	<u> </u>	77.09	nang	reton,	by	press	24a. Was		prior to co	opsy findings available ompletion of cause of											
Vital Records,	ician: The certificate ha								10	<i></i>	perfo 1 □ Yes	2 X No	death? 1 ☐ Yes	2 No											
V:	nysician: nis certific director, I) Be	25. Was case referred to m examiner? 1 Yes 2 No	dical	Hospital:	11	-1 0 - 500		2 Other:	26. Place of Deat				Record											
J Of	ding Phy h. After this funeral d	n: To	27. Manner of Ceath		28a. Date			ie of 28c. I	njury a	4 LI Nursing Ho	me 5 ☐ Resi 28d. Describe			y) Street											
sior	Attendin death. ctor: Aff y the fur	atio	2 Accident ir	ending vestigation	1	riui, Daj	<i>i, Year)</i> Inju		Vork? I∐Ye:	s 2 🗆 No				TTOME											
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to	Certification:		ould not be etermined	e 28e. Plac build	e of Injuding, etc	iry - At home, farm c. <i>(Sp</i> ec <i>ify)</i>	, street, factory, offi	ce		28f. Location (a City or Tox	Street and Nu wn, State)	mber or Run	al Route Number,											
ч	spital		29a. Certifier 1 Ce	tifying Pl	nysician: To th	ne best o	of my knowledge, o	leath occurred at th	e time.	. date and place.	and due to the	cause(s) and	manner as	stated.											
	he Ho in 24 ł he Fu pletely	Medical	(Check only 2	lical Exar	niner: On the	basis of nner sta	fexamination and/∈	or investigation, in r	ny opin	nion, death occur	red at the time,	date and place	e, and due t	o the cause(s)											
	Vith Con H	Σ	29b. Signature and title of c	rtifier)/.	//	1 1/1	29c. Lic	ense n	number		29d. Date sig	ned (Month,	Day, Year)											
			- Ah	-	1.0	12	with the	200	35	183	4	prif	29,	2010											
	2		30. Name and address of pe	rson who	completed cau	1-1		pe, Print) Oe We	201	+ ath	Str	FF.	Nor.	d mi											
	Sta	te	31. Date filed (Month, Day,	(ear)		- /	r's Signature			/	-160	11/6	utre!	ex pril											
	Registra	ar	Ai	K 3 (2010	De	never &	. Backs																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APRII Physician/ 2010 1:20 P M RANKO **PETAR** ZIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 6820 TILDEN LA. NORTH BETHESDA 8. Date of Birth (Month, Day, Year) AUG . 27,1928 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 □**X**M 2 □ F CROATIA Director 072-34-2119 81 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD. MONTGOMERY NORTH BETHESDA 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 6820 TILDEN LA. 20852 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: "natural" 3
Widowed 4 Divorced WHITE Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION CIVIL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ZIC FILKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6820 TILDEN LA., DARINKA ZIC/WIFE NORTH BETHESDA, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-3-2010 RIVERDALE, MD. 21. Signature of Funeral Service Leensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
2 WEEKS Immediate Cause (Final . Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YEARS AMYOTROPHIC LATERAL SCLEROSIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea4 ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown P.O. Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed⁴ 2 X No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo ၉ 1 🖵 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in the opinion, uean occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 30, 2010 MD0052247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7625 WISCONSIN AVE. #101, BETHESDA, MD. 20814 COLLIN D. CULLEN, M.D.

State

Registrar

31. Date filed (Month, Day, Year)

03

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eugene Month Day Year 2156 Roland 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center 7. Age (In yrs. last birthday) 46 yrs. Social Security Number If Under 1 Year If Under 24 Hrs.

Months

10c. City, Town or Location

Whiteford

Days

21160

1 ☐ Yes 2 🕅 No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

16a. Decedent's Usual Occupation

Master Electrician

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Min.

8. Date of Birth

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Ann Jacobs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1557 Main Street, White oria, Mariyiand 21160

01900t2 8ax 1983

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Tes 2 X No

Marrialand

10g. Citizen of What Country? United States of America

14. Race - American Indian, Black, White, etc.

Specify:

16b, Kind of Business Industry

Construction

Physician/ Medical **Examiner**

214-76-5865

10a. State

Maryland

11. Marital Status

10e. Street and Number

Director

Funeral

þ

Completed

Be

2

Usual Residence of Decedent

1557 Main Street

1 Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

10b. County

Harford

15. Decedent's Education (Specify only highest grade completed)

17. Father's Name (First, Middle, Last). Eugene Roland Zellman, Sr

19a. Informant's Name/Relationship (Type, Print)
Peggy A. Zellman (Wit

1 🛛 M 2 🗆 F

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

College (1-4 or 5+)

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical **Examiner**

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by of completed filled in by the funeral director, page 2 should be detact

INSOCHOSS (p. Division of Vital Records, P.O. Box 68760

20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Di cemetery, RA FEUU	rematory or o	Inc.	05/06			ter, Pennsylva
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, 123 S Washington St., Havre de Grace, Ma								
23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ary o		e of dying, such			rest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	f any, leading to immediate Due to (or as a consequence of): Jause, Uisease or linjury hat initiated events C.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp				23d. Date o	,
Part II. Other significant conditions of	ontributing to death but	not resulting in the	ne underlying o	cause given in F	art I.	1		ite to the cause of death?
						24a. Was auto perfo	osy prid ormed? dea	re autopsy findings available or to completion of cause of th?
25. Was case referred to medical				26. Place of I	Death (Check	only one)		
examiner? 1 ★ Yes 2 ☐ No	Hospital:	t 2 ER/Outpa	ntient 3 🗆 DO	OA Other:	Nursing Hon	ne 5 🗆 Besi	dence 6 🗆 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day,	28b. Tim	e of 2	28c. Injury at work?			now injury occurred	
4 Homicide determined	City or Tou							
(Check 2 L Medical Exam	sician: To the best of m ner: On the basis of exa se Practioner: To the be	mination and/or in	vestigation, in 1	ny opinion, deat	h occurred at t	the time, date a	ind place, and due to	the cause(s) and manner stated
29b. Signature and title of certifier			29c	. License numb	er		29d. Date signed (A	fonth, Day, Year)
1 / Muss	alle 1	10	1	0006	603	5	5.1.2	010

500 Upper Chesapara Dr. Belkir MD 21014

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremu 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5586 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Alexander na 2010 Α. Sabina /Medical MA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pikesville Baltimore Co. Courtland Manor If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/18/1926 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Virginia 1 □ M 2 🔀 F 224-58-2249 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X☐Yes 2☐No Director Baltimore N/a MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 6719 Chisholm Funeral Dr. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes Molf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 2ĂNo Baltimore, Maryland 21215-0036 Specify. Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) A&T state Univ. Librarian years injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwards Mary ဂ္ Jesse В. Anglin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other trau 6719 Chisholm Dr., Baltimore, MD 21207 Denise A. SMith(Daughter) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition AHASEPEMETORY or other AHASEPEMETORY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/16/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) on H. Brown Jr. Funeral Home N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 21217 23a. Parl 1. Ent / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the a 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 1 ☐ Yes 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 2 No 1 Inpatient 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation after death. 1∏Yes 2∏No 3 ☐ Suicide 6 ☐ Could not be within 24 hours after dea To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier eompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who, 434 & Belvelie and Rellipore

State Registrar

Alexande

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** PM 2010 0815 ene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOS AGNES BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | (Month), Day. 7. Age (In yrs. last birthday)

4
Yrs. Social Security Number 6. Sex Funeral 1 □ M 2 🗖 F New Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Exactional be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 XYes 2 □ No Funeral Director imore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) omemak 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa Mame/Relationship (Type. Print) (daighter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility
OSCON L. Russ
2222 W. North 21. Signature o Funeral Service Licensee 23a. Part 1 Enter the disease, of complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lit only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 MONTH **Physician** NEUMON/A disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. loi Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Řecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STAGE RENAL 24a. Was an 24b. Were autopsy findings available , page 2 autopsy performed? prior to completion of death?

1 Yes 2 No or Attending Physician: The 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27, Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATONAUE. BALTIMORE MO 21229 JON ANTAN ONQUIL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 19 2010 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G903, 5/19/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day BUCKHEIT GEORGE 8:00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDA LLSTOWN RANDALLS GENESIS TOWN 7. Age (In yrs. last birthday) 70 yrs 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1939 Birthplace (State or Foreign Country) **Funeral** Hours 12/10/5830 Director 217-48-5830 MD Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5018 Wards Chapel Rd 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 K Never Married 2 Married 1 Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. White Specify: 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George A. Buckheit, Sr. Marie Felte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Brady (Brother-in-law 5018 Wards Chapel Rd. Owings Mills, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Meadowridge Memorial 5/20/2010 4 Donation 5 Other (Specify) Elkridge, MD Signature of Funeral Service Purrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 2178/4
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death

months Immediate Cause (Final ASPIRATION PNELIMONIA Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Veal Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, cate has been sig , page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) 2 🔀 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛛 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 96 58 D00 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAIMIA KHAWAJA 21234 TIMORF MD d 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 19 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Herbert Bernhardt Unu 0323 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Smailtospital of Balkmare Baltmore Cety Mayland Balkmore, Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Jan 1 , 1915 1 M 2 □ F Hours Pennsylvania Director 220-12-8782 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: It item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3116 Bancroft Road; Apt B 21219 USA 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Specify: 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mathematics teacher education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Michael Bernhardt Frieda Bauron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Babette Bernhardt/spouse 3031 Fallstaff Rd; #204; Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Service I censee Ronal Wa 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 Wade ector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final PREVMONIA Physician/ disease or condition resulting in death) 94 Medical Due to (or as a consequence of): Examiner 1 dorn Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): attending physician Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 ☐ No 1 Yes 2 L 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? After this certificate Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₺ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No 1 Natural 5 Pending after death. Accident Suicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000

Registrar
DHMH 17 Rev 7/2009

State

2401 W. Belvedere Ave Baltmore, MD 2H15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Heresch,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 10 Butler 4:15A Harriet Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Silver Springs Holy Cross Hospital 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Birthpia Country) York **Funeral** 1 M 2 M Days Hours Min. 0974 84/ ″f°951 Director 070-42-9779 58 New Usual Residence of Decedent 10b. County Prince or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No George's Silver Springs Co. 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20902 U.S.A. 3608 Randolph Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n/a 12th Grade HomeMaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elzie Walker Ethel L. Murdough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny Butler Jr. (son) 113 Walnut St.#67 Neptune, NJ 07753 20b. Place of Disposition (Name of cemetery, crematory or other place)
Monmouth
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/21/10 Tinton Falls, N.J. 22 Name and Address of Facility Jackson Funeral Home 242 Neptune BLVD, Neptune, N.J. 07753 Signature of Funeral Service Licenses Ne 23a. Part 1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Section 5. Approximate Interval Between Onset and Death Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Calorie malnutrition 24b. Were autopsy findings available 24a Was an prior to completion of cause of performed? certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical (Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signa

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 17, 2010 5:05 P M Mary Beck May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Keswick Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country) District 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1 □ M **X**XF Jan. 4, 1919 91 216-18-0999 Columbia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes XXNo MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4013 Buckingham Rd. 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes X2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ YesXX☐ No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Macias White William Henry Waggaman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Willow Ave. #8 Hoboken, N.J. 07030 Walter Lee Beck, Jr. / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/21/10 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) Veterans Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee form? mn 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2,☐ No 9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be

Examiner Physician/Medical ò Completed Be ٩ Certification:

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

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Department of Health al
Important: If Item 27 is
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/Medical

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Director

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and 2 should be filed within 72 hours after or ealth and Mental Hygiene.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 ☐ Homicide 29a. Certifier (Check only

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D35102

28f. Location (Street and Number or Rural Route Number, City or Town, State)

18 2010

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

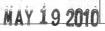
Mall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M M

and manner stated.

5961 north CHarles Street Baltimore MAr DON M.D. 31. Date filed (Month, Day, Year) - 32. Red ar's Signature

Registrar



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 15592

		1- For State Certificate of Death Reg. No.
Physici Medical Exam	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year ODFO here
Medical Exam	mei	Iszard Ballard, Jr. May 13, 2010 950 nrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		18800 Roxbury Road Hagerstown Washington
Funeral Director		5. Social Security Number 214 98 2717 6. Sex 17. Age (In yrs. last birthday) 12 F 42 Yrs. 6. Sex 17. Age (In yrs. last birthday) 15. Social Security Number 214 98 2717 15. Sept. 10, 196 7 Country) 9. Birthplace (State or Foreign 7 Country) MD
à		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
nd show a	Ļ	MD n/a Baltimore $1 \times Y^{\text{es } 2} \cap N_0$
Aarylaı 28a-fş 1 at on	Director	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f show any notified at once.		1315 N. Aisquith St. 21202 USA
r death w or items must be	Funeral	11. Marital Status 1
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
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-003 I within giene. ther th	Completed	2 yrs Building Maintenance Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
215 be filed rital Hy ent, th	Be C	Iszard Ballard, Sr. Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21215-0036 d 2 should be filed within 72 hours after that and Mental Hygiene. m 27 is marked other than "natural", aumatic event, the Medical Examiner	J.	
, ME and 2 s ealth a em 27		Iszard Ballard, Sr. (father) 1315 N. Aisquith St. Balto, Md. 21202 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		1 K Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: King Mem.Pk. May 21,2010 Balto,Md.
Bal permit Depar Impo		22. Name and Address of Facility Calvin B. Scruggs Funeral Home
Physician	-4	Calvin B. Scruggs Funeral Home Calvin B. Scruggs Funeral Home Preston St Balto Md 23a. Part I. Enter the disease, or complications that caused the Sh. Do not enter the mode of dying, such as carolac or respiratory arrest, shock, or heart gailure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Acquired immnuodeficiency syndrome Death
		or condition resulting in death) Due to (or as a consequence of):
	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
760, icate be executed physician and the burial - transit	al Exa	events resulting in death) Last Due to (or as a consequence of): d.
760, cate be executed physician and the burnal - trans	ledical	Amend/ Unpend-#1 as noted, 23a,27, per ME g905 7/13/10 TT
Box 68760, e death certificate bo the attending physic ed for use as the bur	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
Bo he dear	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68' Is a or Attending Physician: The law requires that the death certify as after death. After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as 1	by	1 Yes 2 No 3 Probably 4 Unknown
tal Records cian: The law requi certificate has been ector, page 2 should	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?
Vital Rec ysician: The his certificate director, page		1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
/ital	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 V Other: Scene
of Viring Physical After this Tuneral direction		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
sion trendi death. ctor: /	atio	1 Yes 2 No
Division of Vipital or Attending Phous after death. Beral Director: After titled in by the funeral	ertification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (28f. Location (Street and Number or Rural Route Number, City or Town, State)
10. 8 a 12.	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
1/0	29b. bignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 14, 2010	
NON		30. Name and address of person who completed cause of death (Item 23a)
1 1		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
		31. Date filed (Month, Day, Year) 32. Register's Signature A Y 1 9 2010 A A WAY 1 9 2010
Regis	ueu	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallytown ltimore OLD COURT CARE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/25/1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 85 Maryland 218-14-5299 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director N/A Baltimore MD 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 U.S.A. 901 Cherryhill Rd. Apt. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify Baltimore, Maryland 21215-0036 Black 3€ Widowed 4 Divorced 16b. Kind of Business/Industry
Baltimore Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing Authority Receptionist 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Gardner Steven Lievers 19a. Informant's Name/Relationship *(Type. Print)* (Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Maybin Circle, Owings Mills, MD 21117 Jeffrey Crockett(Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Joseph Brown F/H Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/19/10 Baltimore, MD 5 ☐ Other (Specify) And 4 ☐ Donation ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21. Signal re of uneral Service Licensee 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a considerate of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trace Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 2 No Sphagia this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 ☐ Accident 5 □ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65046 2010

DHMH 17 Rev 1/2001

State Registrar

AMBALAVANAN 31. Date filed (Month, Day, Year) 9 2010 BACASUBRAMANIAN MP, 2600 LIBERTY HTS AVE MD 2/2/5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18,19b, perFH, G903,5/1972010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Month Day RICHARD J. CARROLL , JR. 8:29 PM MAY 17 201C Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARY LAND MEDICAL CENTER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. May 4, 1950 1 😿 M 2 🗆 F Hours 217-54-1638 Yrs. Director 60 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2511 Loretta Avenue 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene other th Laborer Construction other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even and Mental h ည Joseph Carroll Sr. Teacher Richard Bernice 19a. Informant's Name/Relationship (Type, Print) 1919 bigiiga Address(Sigataed Number or Rurah Royae Augmes (Ebro 170 Box 21203, Baltimore, MD 21203 or THD S21-218 ode) Theresa Ann Carroll/Ex-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \square Burial 2 🗷 Cremation 3 \square Removal from State 5/20/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota, Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore,MD 21203 Moushall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AVOXIC BRAIN INTORY
Due to (or as a consequence of): disease or condition WEE Medical resulting in death) **Examiner** Sequentially list conditions, if any, is a ling to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events VENTRICULAR FIRRILLATIO WEEK Examine Due to lor as a consequence of WEEK HYPOKALEMIA resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign HYPOXIC RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an END STAGE RENAL DISEASE autopsy page performed? 1 ☐ Yes 2 ☑ No certificate å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 1346475191 MAY 17 2010 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 22. SOUTH GREENE ST., BALTIMORE MD 21201 SARAH GOLDBERG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5595 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles M. Cole, Jr. Month Physician/ Year May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, 4c. County of Death or Location of Death Examiner 1000 8. Date of Birth If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 9. Birthplace (State or Foreign Year **Funeral** Months Days June 16 1 🖾 M 2 🗆 F 65 Hours Yrs. 1944 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21217 1802 Eutaw Place 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married I ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes. Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame)
Corintha A. Haskins ဂ Charles M. Cole, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Snowden River Pkwy, #410, Columbia, MD 21045 Elizabeth T. Cole / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State matory or other place) 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 5/18/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Coronar disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 s. autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ည 1 Inpatient 2 KER/Outpatient 3 IDOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë. 28d. Describe how injury occurred X Natural injury 5 Pending Certifical 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 85-000

State Registrar Hoigail

, Baltimore mis ziza

WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lenhau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Joseph Burl Celestand Month 12 May 10:30a™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard Birthplace (State or Foreign Country)
____ Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 1 🛛 M 2 🗆 F Days 439-14-5588 **Director** 87 8/22/1922 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD Howard Ellicott City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Cltizen of What Country? Funeral items 23a 3047 Mullineaux Lane 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1X Yes 2 No1942-44 Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black Specify: 3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates. **US** Army or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Worker Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Celestand Gession Effie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Alberta J. Ackers/Step-Daughter 4156 Convention Street, Baton Rouge, LA 70806 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 ☐ Removal from State Final Journey Ctrem. 5/15/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1413, Baltimore, MD 21. Signature of Tyneral Service Liousee Dorota Marshall llarchall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Emphysemo resulting in death) Medical Due to (**Examiner** Dementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 M Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No Hospital Other: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 U Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 □ Yes 2 □ No after death.

Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

ク State 29b. Signature and title of certifie

MYTHILY 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

Registrar

MD

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32. Regis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0064760

charter Drive Suit 310, Columbia, MD.

29d. Date signed (Month, Day, Year)

May

19,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 9,10a-c,e,f,15,18,19a-b, per ab g904 6-3-10 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:05 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BON BALTIMO SECOURS HOSPITA Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** South Carolina Hours Min May 28, Ye Director T931 78 216-36**-**0871 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. Stateunle 10b. County unk 10c. City, Town or Location unk 10d. Inside City Limits Director 1 X Yes 2 No Md. Baltimore 10f. Zip Code Unk 10e. Street and Number tink 10g. Citizen of What Country? 701 Arlington Ave. #410 21215 USA death v 12. Was Decedent Ever in U.S. Armed Forces?unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 Specify: black 1 ☐ Yes 2X No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Un.
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event the Manary or other traumatic event the Manary. Elementary/Seconday (0-12) College (1-4 or 5+) unk 9 unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Mabel Clark 19a Informant's Name/Relationship (Type, Print)
Mary Herrington/ sister
Bon Secours Hospital 19b. Mailing Address/Street and Number or Rural Route Number City or Town, State Zin Code) **815 Jackson Ave. Evansville, IN. 47/13**2200 W. Baltimore Street; Baltimore, Maryl Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signal of Juneral Service icensee de State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Part V. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death CORONA Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): and -transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an has page 2 prior to completion of cause of death? autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 A No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 20030355 0 and address of person who completed cause of death (Item 23a) (Type, Print) SECOURS HOSPITAL RUZ M. A 05 31. Date filed (Month, Day, 32. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 12:48P-M Pauline Juanita Veney Dorsey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 DXF Months Days Hours Min. (Month, Day, Year) 05/16/1931 Virginia Director 217-22-4931 78 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland at 10c. City. Town or Location Director 10d. Inside City Limits r 28a-f st notified 1 Yes 2 X No NC N/A Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 514 Whitten Ave. U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Administrator Lithograph Co. Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Addie Belle Phillip Robert Howard Veney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 Auchentroly Terrace, Balto., MD 21217 Sandra Wallace(Daughter) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Woodlawn Cem. 105/22/10 Baltimore, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day signed by the a d be detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate nours after death.

neral Director: After this certificat
d filled in by the funeral director, ps 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗹 No Other: 1 Inpatient 2 RER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Practionari To the best of my knowle 29b. Signature and title certifier 29d. Date signed (Month, Day, Year)

8

DHMH 17 Rev 7/2009

State Registrar E. UNIVERSITY PARKWAY, BALTIMORE, MD. 21218

NO

eted cause of death (Item 23a) (Type, Print)

201

Registrar's Signa

30. Name and address of person who com

eku

DANIEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 5 9 9

		1- For State Registrar		Certific	cate of	Death			Reg	No.	. 0	
Physici Medical Exam			Duncan, J	r						ay Yea		3. Time of Death
Medical Exam	mei	4a. Facility Name (if not institution,		I •	41	. City, Town, o	or Location of		May 2, 2010	4c. County of	of Death	0310185
		Ft. Washington Hospita	đ			Ft. Washin	ngton			Prince G	eorge'	S
Funeral Director		5. Social Security Number 579-72-1076 1 X M 2 F 55 Yrs. 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birth (Mm/DD/YYYYYY) 9. Birth (Mm/DD/YYYYY) 9. Bi						Foreign	place (State or Washington of the Constitution)			
any		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town	n or Locatio	n						10d. Inside City Limits
* .	F	Maryland Prince	e Georges	For	t Was	nington	ı		1 X Yes 2			
Maryland 28a-f show d at once.	Director	10e. Street and Number		-	<u> </u>	10f. Zip Code			10g	Citizen of Wh	nat Count	γ?
th the l 23a or 10tifie		13402 Colfax				207	44		τ	Inited	Stat	es
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Nijoror	12. Was Decedent E Armed Forces? 1 Yes 2 Ced If Yes, Give Year	No No	If Yes	Decedent of H s, specify Cuba 'es 2 X No	an, Mexican,			14. Race White Specify:	e, etc.	an Indian, Black,
ours af atural'	d by	15. Decedent's Education (Specif	or Dates:	leted) 16a.	Decedent's	Usual Occupa	ation (Give ki			6b. Kind of Bu		
6 n 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	-)		t of working life		use retired)				
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21215-0036 ald be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	David Duncar	•					nora	Cope 1		,	
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nd 2 alth 3 m 2 m 2 raum		Elreater Patte 20a. Method of Disposition	erson			Asbury on (Name of ce		e;For		ngton,		land 20744
5 2 3 3 4 8 1		1 ABurial 2 X Cremation 4 Ponation 5 Other Spec	cify:	Resur	tory or othe	on Ceme Crema	tery	May 1	7 ,2010 20,	Clinto Beltev	n, M	aryland Maryland
Baltimo permit. Pag Department Important: injury or ot		21 Si ma ure of in neral Service Li	censee			me and Addres	-	Free	man Fur	neral S	ervi	ces
Physician	-	23a. Firt I. Enter the disease or confa ure. List only one cause or	emplications that caused th	e death. Do n					le Hill piratory arrest			Approximate Interval
/Medical			each line. Narcoti a_ <u>complicati</u>									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence									
	ē	Sequentially list conditions, b							-			
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recuted and transit		events resulting in death) Last	d					77	- 20			
760, cate be exec physician a he burial - t	Medical	X UNPENDED	X AMENDED 23a, 16a-b, 20	PII,27	,28a- er FH	1,per 1	ME G90 /19/10	3 5/2 7 TT	20/10 T	Т		
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Box 68° e death certificate at the attending ed for use as	iciar	past 12 months?	1 Live birth 4 Pregnant at tin	f -l 41-		death 3 (Specify)	Ectopic p	pregnancy		Month	Da	y Year
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ords, P.O. B w requires that the d s been signed by the	اھ	Part II. Other significant condition	ns contributing to death b	out not resultin	ig in the und	lerlying cause	given in Part	1.			_	e cause of death?
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e law re has t	E E								autopsy performe	<u>:d</u> ? d	eath?	npletion of cause of
Division of Vital Records, rate or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fineral director.		25. Was case referred to medical	 			26.Place	e of Death (C	Check only	1 ✓ Yes 2 one)	1	✓ Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No		2 🗸 ER/O	utpatient	B DOA	Other ₄	Nursing Ho	me 5 Re	sidence 6	Other:	
n of Vi ding Physi After this funeral dir		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year	- 1	Time of Inju		iry at Work?		Describe how	injury occurre	ed	
isior Attend r death ector: by the	icati	2 Accident Investig	pation Plans of Injury		2:28	am	Yes 2X N			et and Numbe	r or Pura	Poute Number City
Divi	Certification:	3 Suicide 6 X Could n 4 Homicide determi	lot be	ouse	ann, sacci,	ractory, omice i	odilding, etc.	Fc	or Town, State	13402 hington	Colf	Route Number, City ax Dr
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my k					e, and due	to the cause(s) and manner	as stated	cause(s)
E. M. E. S	₩	29b. Signature and title of certifier	and mariner stated.		· · · · · · · · · · · · · · · · · · ·	29c. Licens	se number		2	9d. Date signe	d (Month	, Day, Year)
		unet?	appypor umit			O.C.	M.E.		V	<i>I</i> lay 3, 2010)	
2V		30. Name and address of person what Ana Rubio MD. Assis	no completed cause of dea tant Medical Examin		Penn Str	eet, Baltimo	ore, MD 2	1201	•			
St Regist	335	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	6 1	arkel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11210 Month FRONICA 2010 MA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER NESTAINSTER CARROLL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 AF Hours 093-40-798 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits notified 28a-f CARROLL 1 Yes 2 □ No ELNERSBURG 10e. Street and Number 10g. Citizen of What Country? must be Funeral 5637 RARTHOLOW ROAM SIA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specif.: 3 Widowed 4 Divorced Specify. Completed WHITE the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER 0 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မှ SEPH HELEN permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GABRIELLA 7 BARTHOLOW RU ELDERSBURG MO 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19/200 WINFIELD, MD Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBUN FH & MON Co SYFESVILLERO ELDERSBURG- MO Part 1 Poter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate name. From the deriving Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed ND. Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer work?
1 Yes 2 No 1 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) S. Siddlia D30 119 5-18-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #17 & 18 per AB g903 5/19/10 TT/ #19a-20c, 22perFH, G903, 5/25/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Juliette Dowery A^M May 13 2010 2:01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 2, 19 Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 □ M 2 🛛 F 579-98-1970 Yrs 75 Director 1935 Alabama Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be multimed at MD Montgomery Takoma Park 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7510 Chestnut Avenue 20912 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 21X No Specify Specify: black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 housewife own home 17. Father's Name (First, Middle, Last)unk 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Catherine Barlow William Rudder, Jr. 19a. Informant's Name/Relationship (Type_Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)

Buccaneer Rd. Silver Spring, MD 20904

13102 Buctaneer Road; Silver Spring, Maryland 20904 permit. Pages 1 and 2 and 1 and 2 and 1 and 2 an Nathaniel M. Dowery/Son 20a. Method of Disposition
1 □ Burial 2 💆 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 5-20-2010 Alexandria, VA 4□Donation 5⊞Other (Specify) -in 5tate Name and Address of Facility Francis J. Collins Funeral Home Inc 300 University Blvd. Vest, Silver Spring, MD Baltimore, Maryland 21201 21. Signature Funeral Sevice Licensee Director 2222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTORY DROWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed burial-1 Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical as aftending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t page 2 sl performe certificate 1 □Yes 2 - No 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: A No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUDQU D40324 MAY 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THROMA PARK, MAPULAND TERRY JODRIE, MD, FACEP 7600 CARROLL AVENUE,

State Registrar 31. Date filed (Month, Day, Year)

32.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 2010 Desantis obert, S. 6: 10 PM Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical (eviter 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 X M 2 □ F (Month, Day, Year) Days Hours Min. Country) **Director** 165.38.3404 Feb 22, 1949 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 6064 Warm Stone Court 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank J. DeSantis Natalie Brotemarkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Mary Lou DeSantis 6064 Warm Stone Court Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) May 18, 2010 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature of F peral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicett City, MD 21043 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate use (Final disease or ondition resulting in death) Physician/ Myelofibrosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown P Month Day Year by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗀 No Yes 2 X No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1

Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. I Director: After t Certificate: 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death.

To the Funeral Director: After 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Inoopa Koshy, M.D 18193 May, 17, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Anoopa Koshy, , Baltimore MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 15:00 2010 au /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bayriew Medical lenter Baltimore topkins 8. Date of Birth (Month, Day, Year) August 10, 1944 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2 □ F Maryland 212-46-8979 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evar-in at runst be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Edgemere 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21219 USA 7509 Iroquois Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local 16 12 years Ironworker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mildred Simpson John Darr ್ತ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **21**811 1129-14 Grays Corner Road, Berlin, Maryland James H. Darr Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 Bayview Crematory Signature of Funeral Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dai disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) its certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEDIN. Caroline Street

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7:15 PM 2010 Dorthula R. Fletcher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Itimore da 8. Date of Birth (Month, Day Year) 928 If Under 1 Year Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 □ XF 159-24-7759 81 Yrs Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Baltimore Director Middle River 1 ☐ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1117 Fuselage Avenue 21220 Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 X Widowed 4 ☐ Divorced "naturai" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Homemaker own home 11th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin L. Mellott ျှ Myrtle E. Mellott or other traumatic Health and Nem 27 is mai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nila C. Ledford /daughter 1800 Peachtree Court Fallston MD 21047 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Whips Cove Cemetery 5/18/10 WarfordsburgPA 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} 300 Mace Ave, Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Fune al Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Lectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 2 No 1 ☐Yes 2 🗹 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after dea...ral Director: Aff 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) BINIT H, 5/14/10 NOUYEN D65094 30. Name and address of npleted cause of death (Item 23a) (Type, Print) 10 Drive Baltimore MD 21237 BinbA 9000 tranklin Quare

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sterlyn C. Green 05:30AM mar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randa**11**stown Social Security Number 7. Age (In yrs. last birthday) If Under 1 **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **X**XM 2 □ F (Month, Day Year) ep. 10,1927 Months Hours Min 82 Director 220-24-4293 Sep. Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f st notified a MD Ba1timore Pikesvi**11**e 1 Yes XXNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Completed by Funeral 611 Reisterstown Rd. 21208 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea ₩idowed 4 □ Divorced 1 ☐ Yes XX No Specify. White Specify. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Freight and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Green Madge Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Ronald Green / Son Ivy Bridge Ct. Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Druid Ridge 5/20/10 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD Cemetery permit. u eral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mi**11**s, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Proysician/ 475 ahcev disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in modiate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of): resulting in death) Last physician s the burial /Medical The law requires that the death certificate be Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: After this of funeral din ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) In P+ 1403 p.16 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D3405 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 Aviation Blud 21061 baum

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla Registrar		artment of I rtificate of I		Mental Hy	giene Reg. No.	15607	
	Physicia		1. Decedent's Name (First, Middle, Last) Alma Wilhelmina Horner				2. Date of De Month May		3. Time of Death 8:00 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Senior Constant Care	4c. County of Death Carrol1						
	Funeral Director	Г		. last birthday) Yrs.	Winfie If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th g. E	irthplace (State or Foreign	
		١	Usual Residence of Decedent	City, Town or Lo	cation		puly 24	1915	MD 10d. Inside City Limits	
	Marylar 28a-f s notified	irecto	MD Howard	Elkri	dge			1 ☐ Yes 2 🛣 No		
	s 23a or	Funeral Director	10e. Street and Number 6058 Hunt Club Road		10f. Zip Code 21075			10g. Citizen of What (Country?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	l I	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣 No	an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	within 72 hor giene. er than "nat , the Medice	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12	(Give I	dent's Usual Occup kind of work done o O NOT use retired) Bookk		rking	16b. Kind of Business Industry Commercial Tire		
land	be filed lental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) George Edward Staedtler				me <i>(First, Middle</i> , ıra A. Kı	e, Maiden Surname)		
, Mary	nd 2 should saith and M n 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print) Charles Horner, Jr./Son	Zip Code) 21776						
imore	. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposition 1. Solution 1. Solution 2 □ Cremation 3 □ Removal from State Nea. 4 □ Donation 5 □ Other (Specify)	Place of Disportance of Disportance of Couring	sition (Name of natory or other place e Mem Pa	ark May	Date 19 2010	20c. Location - City of Elkridge,		
Ball	permit Depart Import any inj		21. Signature of Eugeral Son Vicen				•	een Funeral Vinfield, M		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Qnset and Death days	
	Examiner	<u>.</u>	Sequentially list conditions by Bronchie				years			
h	uted Id ansit	Examiner	if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consect or cons	quence of):						
760	cate be executed physlcian and s the burial-transi	ledical E	resulting in death) Last Due to (or as a consected d.	quence of):						
Box 68	death certifi ne attending ed for use a	≥ Ι	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregrate 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		23d. Date of d	elivery Day Year				
	requires that the been signed by the should be detache	ρ	Part II. Other significant conditions contributing to death but not re Vascular Dementia	ven in Part I.		obacco use contribute t	o the cause of death?			
ö	has has	Completed						s an 24b. Were autopsy findings available prior to completion of cause of death?		
/ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inserticate 0.5		Otho	ace of Death (Chec			sted Living	
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	4	lome 5 Resid	ence 6 Other (Spe	cify)	
DIVISION	al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specification of the state of the sta	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	(Street and Number or Rural Route Number, wn, State)		
	the Hospit in 24 hour the Funera	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination of the best of my know 2 Medical Examiner: On the best of my know 2 Medical Examiner: To the best of my know 2 Medical Examiner: To the best of my know 2 Medical Examiner: To the best of my know 2 Medical Examiner: On the best of my	on and/or investi	gation, in my opinio	n death occurred a	at the time date a	nd place, and due to the	cause(s) and manner stated	
			29b. Signature and title of certifier 3		29c. License D33			29d. Date signed (Mont May 19, 20		
	10		30. Name and address of person who completed cause of death (Iter M. K. MCEVOY 1380			LDERSBUR	G, MD 21	784		
	Stat Registra	e r	31. Date filed (Month Day Year) 32. Registrar's Signal AV 19 2010	dark.	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year 05 09 2010 /Medical 4:00p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2731 Beryl N/A Ave. Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/28/1921 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Director 250-38-9885 88 S.Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, I'm Modical Examinar must be notified at Director 1X Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2731 Beryl 21205 Ave. U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2⊠No 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade maintenance Levindale N/H permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Redmond ပ Harper Carrie MCNeil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia McFadden(Daughter) 8 Chadbury Ct., Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery crematory or other p Joseph Brown And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 05/12/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign dure of Juneral Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 6. 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im diate Cause (Final SEPTIL Physician SM-Och disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 → No 3 □ Probably 4 □ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 🗆 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) 5 Residence funeral 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records,

72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director:

State Registrar

completely

Medical

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIGITM GATINOUM MOZIOGO

determined

4 - Homicide

(Check only one)

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Heard 11:30 int MA 15 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Numb Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin-Code Ъ 21205 Avenue 23a Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monce. perator Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number Keynolds 50ad 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 5 Other (Specify) Donation of Funeral Serv Name and Address of Facility lund ZIZIZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Due to o as a consequence of) disease or condition resulting in death) /Medical **Examiner** coagulopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed irchosis Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 attending 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 2 No Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: $_{4} \square$ Nursing Home Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 🗌 Yes 2 🗌 No investigation Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide n 24 hours aft e Funeral Di etely filled in 29a. Certifier (check only 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 may 15 RES - 000 30. Name and address of person who dimpleted cause of death (Item 23a) (Type, Print) WOUF JOSHVA 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Luther Day 20 Year Hunter Month 10,191 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALTIMORE GLEN BURNIE WHEHINGTON MEDIENE ANHE + 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 166-05-8779 1 🛛 M 2 🗆 F Months Hours h 18,1918 March March Country) Director 92 Yrs. Usual Residence of Decedent show 10a State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 21401 10e. Street and Number 10g. Citizen of What Country? 1957 Valley Road Funeral USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Yes 2 \sum No WW II Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland-⊉1215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White Completed 3 XWidowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Chemist Chemical Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last)

John Hunter Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Maggie Smith ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, としてあれ Richard Koveland / Son-in-Law 1966 Valley Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 5/16/2010 Woodbine, MD 21. Signature of Funeral Service Licensee Darota 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1413, Baltimore, MD Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ E23 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi TIE 16 Due o (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendina physicis Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No ည Other: ER/Outpatient 3 DOA 1 🗷 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined. City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete Death (Item 23a) (Type, Print) len Busive MB 20161 ١0 31. Date filed (Month) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 ELIZABETH HEIL Physician/ CATHERINE MAY Month 17 12:40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ROSEDALE FRANKLIN WOODS REHAB. CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 217-09-7919 1 □ M 2 🖳 F 90 Yrs Hours 7-14-1919 MARYLAND Director Usual Residence of Decedent show ul Hygiene. I other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director RASPEBURG BALTIMORE MD 1 ☐ Yes 2 ☐ X lo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21206 U.S.A. 24 McCORMICK AVENUE filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry STEWART'S DEPARTMENT Elementary/Seconday (0-12) College (1-4 or 5+) SALES STORE Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental ! (WOLFE) t. Page 1 and 2 should be fil tment of Health and Mental trant: If item 27 is marked jury or other traumatic ew MARY ပ္ HARRY KINGSMORE 19a. Informant's Name/Relationship (Type, Print)
MARY ELLA HEIL/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 24 McCORMICK AVE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) GARDENS OF FAITH ! 5-20-10 BALTIMORE, 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir physician and s the burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ tive Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier signed (Month, Day, Year) 29d. Date 8 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EBO, MD MACE ESSEX, MD 21221

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 15613 State of Maryland / Department of Health and Mental Hygiene

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11215-0036 do filed within 72 hours after fental Hygene. narked other than "natural", event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, L	ast)				me (First, Middle,	Maiden	Surname)	-
212 ould be Menti mark ic even	P	Thomas Harle 19a Informant's Name/Relationshi	p (Type, Print)	19b. Mailin	g Address (Stre		Tyler or Rural Route Nu	mber. Ci	tv or Town, State	Zip Code)
MD d 2 shc lth and n 27 is aumati		Ronald Lee	Brother				Essex,			1221
rre, sland friten friten friten		20a. Method of Disposition 1 X Burial 2 Cremation		b. Place of Dispo- crematory or of			Date May 19,	20c. l	Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Spec	cify:	rownsvil	le VA Cm		2010	Cro	ownsville	e, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		2). Si ature of Funeral Service Li	censee) 22.	nnelly F	uneral	Home of	Dunc	dalk,P.A.	
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Division of Vital Records, P.O. Box 68760, note the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Examiner	X UNPENDED	AMENDED PII, 27,	.28a-f.ne	r ME G91	04 6/1/1	IO TT			
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Division of Vital Records, P.O. Box 68 rate of a strending Physician: The law requires that the death certifiers after death. 1al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	P P	Part II. Other significant condition	ns contributing to death but not cuctive pulmona			given in Part I.				ne cause of death?
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Re ifficate or, pag		25. Was case referred to medical			26 Dines	e of Death (Chec	1 Yes	2 No	1 V Yes	2 No
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Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.		one) 2 Medical Examir	ner:On the basis of examination and manner stated.	and/or investigat	on, in my opinion	, death occurred	at the time, date	and plac	e, and due to the	cause(s)
F3E8	ž	29b Signature and title of certifier	. 1	<u>-</u>	29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
		Wrygene The	Yrull	-13-2	O.C.I	M.E.		May	9, 2010	
		30. Name an address of person who Margarita Korell MD.	o completed cause of death (Ite Assistant Medical Exami		enn Street, Ba	altimore MD	21201			
Sta	te 3	31. Date filed (Month, Day, Year)	32. Registrar's Signa				21201			
Registr		MAY 19	2010 /2	. 1	10. cl. 9					

DHMH 17 Rev 1/2001 OCME 2006

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. nt's Name (First, Middle Last) 2. Date of Death 3. Time of Death Year 19:53 PM **Physician** 2010 6 Whason /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8. GNES SPITAL 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 3 217.68-5070 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Evancine must be rufflied at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Funeral Director Himore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21229 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ۵ 3 ☐ Widowed 4 Divorced Be Completed Decedent's Usual Occupation (Give kind of work done quing life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Name (Airst, Middle, Ma 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Foute Number, City own, State, Zip Code) MD 21208 20c. Location - City or Town, State Place of Disposition cemetery, crematory Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOCK LOURS **Physician** EMORRHAGIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BLEED one DAY STROINTESTINAL Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MONTITS The law requires that the death certificate be executed SOPITA GIAL attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): YEARS RRHOSIS PATI IF FEMALE: yes, outcome of pregnancy
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1 □ Yes 2 → No 24a. Was an certificate has page 2 autopsy perform JOHNSON 2 **2 N**o 1 ☐ Yes or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this Division of funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital t≝ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVENUE BALTIMORE MD 21229 RICARDO SLA BI (ONTI TO Year 31. Date filed (Month Day) State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 8:44AM **Physician** MAY 2010 19m /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ci. BAltimore 15 A 1 timore SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Hours Months Days 218-40-938 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ns 23a or 28a-f show must be notified at 1 Nes 2 No Funeral Director as: WilliAm 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number EdgeNOOA 12. Was Decedent Ever in U.S. Armer Forces?

1 Tyes 2 No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene. Incurs affer Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Modical Examinatonce. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced 1ac 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Known 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a mo 21215 Ke pinora 20b. Place of Disposition cemetery, crematory (Naple of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4-2010 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Vavann Greene Funeral Services Signature of Funeral Service Licenses MI) 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEARI DiseasE Atherosc 1erotic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dusi to for as a consequency of: To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? de 24a. Was an autopsy 4 pertension 1 ☐ Yes 2 No 1X Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0054558 2010 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 HOSPITAL of BALTIMORE SINAI FREDERICK TR BURKE 31. Date filed (Month, Day, Year) State ark Registrar

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	rs afte ural",	<u>ج</u>	3 Widowed 4 Divorced If Yes, or Date 15. Decedent's Education (Specify only high	es:	1 Yes 2 No		tone 116b	Specify: Whi Kind of Business/I	
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	5-0 hed w Hygie other	👸	17. Father's Name (First, Middle, Last)	.		18.Mother's Name (Firs	t, Middle, Maide	n Sumame)	
	121 d be fi lental arked	o Be	James Kyte		10h Mailian Addana (Ol	Lois Camp		O T	7:- 0:-1:)
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other reaumant event, the Medical Examiner must be notified at once.	မ	19a. Informant's Name/Relationship (Type, Pr Lola Doby	sister	19b. Mailing Address (Stre 1826 Kinship				, zip Gode) 222
	s, M and 2 lealth tem 2 traun		20a. Method of Disposition	20b. Plac	e of Disposition (Name of ce			Location - City or	
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	n of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	ica		NDED 3a,27,28a-f,	ME COO2 5	/20/10 TT			
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			30. Name and address of person who complet) I Penn Street, Baltim	ore MD 21201		- 	
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and 2 Notes that the state of t		20a. Method of Dis	sposition	-Husband		Place of Dis	position (Nam	ne of ce	metery,	ROA	ate C7	20c. Location	City or	Town, State
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Ba Depril Imp		V m	MAL	Christin			2. Name and A March	F/Wah	H Wé	st Ave.	Ralt	imore,	Μď	21215
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Box 68760, e death certificate be the attending physicied for use as the burner	an/Medi	IF FEMALE: 23b. Was decedent	t pregnant in the	23c. If yes, outcor	ne of pregr		E-t-Lilians	3	Estania	pregnancy		23d. Date of Month		ay Year
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Dital ours a ceral I	Ser	4 Homicide	determin	ed (Specify) Loc	al Stree	et				100	N. Calvert	Street, Baltim	ore, M)
E Hos		29a. Certifier (Check only		cian: To the best of m										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici contoletely filled in by the funeral director, nase 2 should be detached for use as the burit.	Medical	one) 2 🗸		er:On the basis of examend manner stated.	illiation an	iu/or investi				ureu at the				
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Amend Item 21 per fh,g903,05/19/2010dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:50 PM 2010 Arthalia Manning Ma Medical 4c. County of Death

Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Northwest Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 03/03/1934 219-32-9453 76 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State Director must be notified 1 🗆 Yes 2 🏝 No Columbia MD Howard 9 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21044 USA Funeral 10101 Governor Warfield Pkwy. #119 death or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 X Married Specify: Black Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Baltimore City Guidance Counselor 4 years 12 grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilena Lesane Garthel Kennedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21044 and is m 19a. Informant's Name/Relationship (Type, Print) 10101 Governor Warfield Pkwy. #119, Columbia, MD item 27 Richard Manning, Sr. - Husband 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/13/2010 Owings Mills, MD Garrison Forest VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Road, Randallstown, MD 21133 per DVR Vaughn C. Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Cardiovascular Disease -Atheroscientic Physician Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to edical To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother Specify Other: 1 Tyes 2 LVNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 75 KujapaneMD D0057465 5/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D. 28355mith Av - 5-235 - Bultimore, MD. 21209 N.S. Rajapakse, MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ophelia LaFrancis McDaniel 12:45 PM May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 7 F 0977877877 Washington, DC 62 579-64-2736 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director or 28a-f MD PG Ft. Washington 1 ☐Xes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 9021 Loughran Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed | 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GED Homemaker Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ Marion Thompson Hilda L. Davis Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9008 Goldfield Place; Clinton, Maryland 20735 Yolanda Williams/ Daughter item 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Veteran Cem: 05/24/2010 Cheltenham, Maryland 4 Donathon 5 Other (Specify) 22. Name and Address of FacilityFreeman Funeral Services Signatu 4594 Beech Road; Temple Hills, MD 20748 Part 1. Emer the disease, or col shock, or heart failure. List only Approximate Interval Between Poset and Death of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a cons resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No. 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 No prior to completion of cause of death? After this certificate has I 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 은 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Marrier of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signafure and title of certifier 29d. Date signed (Month, Day, Year) 6V

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No ame (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number)
Season's Hospice 4b. City, Town, or Location of Death Randallstown Examiner Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 321-46-0697 1 □ M 2 🕱 F Months Days Hours Min. Feb. 27, 1949 61 NY **Director** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 614 East 36th. Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. o. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 ☐ Widowed 4 A Divorced "natural" Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Optometrist Optometry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental ည Barbara Juanita Watson Frank Metellus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Hibbard Road, Wilmette, IL 60091 Daniel Coffman / Son 27 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of F Important: If its any injury or ot once. 1 Burial 2 XCremation 3 Removal from State 5/18/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ee 22. Name and Address of Facility remation Services PO Box 1413, Baltimore, MD 21203 Norpta Marshal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate terval Between nset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of **Examiner** usullally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 pronths?

1 Yes 2 No ρō Month Day Pregnant at time of death should be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page 2 death? ☐ Yes 2 \(\text{No}\) Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 20 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Prin

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b per Fh G903 5/25/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:084 ANNATTA 2015 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) Funeral 1 □ M 2 💆 F Months Days Hours Min (Month, Day, Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State death with the Maryland **Funeral Director** 1 ¥ Yes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cemetery 5/29/10 Trinity Signature of Puneral Service Licenses 2. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Septic Physician/ Shoc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pangytopenia Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Multiple been signed by the attending physician and should be detached for use as the burial-transit Myeloma that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Lactic acidosis. Anomia. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No ျှ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Fractioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Lita ∂ MD R&5000 May, 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTOSH DHITAL GOOD SAMARIYAN haspital, Anitimero. MD saltimore. 31. Date filed (Month, Day, Year) 32. Re strar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** BURNETTA SHARRON PRESTON 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Kosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 21 ocial Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 📉 Days Months Hours MARYLAND 1956 53 Director <u>216-72-5</u>602 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location show ral", or items 23a or 28a-f shor Examinar must be coefficed at 1 ☐ Yes 2X No Directo MARYLAND BALTIMORE ESSEX the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A. Completed by Funeral 1626 BROWNS ROAD 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2**XX**No If Yes, Give Year or Dates: 1XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZXNo Specify: Specify: BLACK 3 Widowed 4 Divorced "natural" 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within Tent of Health and Mental Hygiene. 12yrs <u>6yrs</u> SOCIAL WORKER BALTO CITY DEPT OF SS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JAMES N. PRESTON SR. GRACE E. BROWN PRESTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. Edward M. Preston/Brother 1131 Western Chapel Rd., New Windsor, Md., 21776 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HOLLY HILLS MEMORIAL 05-18-10 MIDDLE RIVER, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, 21. Signature Lour 321 S. PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due for as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Vear Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ج</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Hospital or Attending Physician: The 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who

Year)

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country) Director 28a-f show 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Himore 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Black 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) pervisor Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ည a (Street and Number or Rural Poute Numbe<u>r</u> MD 21216 unius OU Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremator) or other place Burial 2 Cremation 3 Removal from State ikesville 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 23a. Part 1. Enter 🖟 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** d.20026 4095 Sequentially list conditions, if any, leading the cause. Enter Underlying Cause (Disease or iinjury ice of or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iis certificate has director, page 2 performe 2 🗌 No Yes 2 N 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 1 _ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No within 24 hours after death

To the Funeral Director: / Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co and address of person who completed cause of death (Item 23a) (Type, Print N. Charles St. 90 01 010 25

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. R

10-03712	
Janice Price	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010	Bester	5	6	2	1
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		1- For State Registrar	Cen	tificate of De	eath	R	Reg. No.		
Physici ledical Exami		Decedent's Name (First, Middle	ast) ICC			2. Date of Dea Month May 14, 2	ath Day Year	3. Time of Death 1500 hrs	
		4a. Facility Name (if not institution, Union Memorial Hospita	give street and number)		City, Town, or Location of D altimore	eath	4c. County of Dea	ath	
Funeral Director		213-10-6695	5. Sex 7. Age (In yrs. la	. "	Under 1 Year If Under 2 Nonths Days Hours	4Hrs. 8. Date of Bir Min. 9/23	73/1958 9. E	Birthplace (State or eign Country)	
nd show any cc.	_	Usual Residence of Decedent 10a. State							
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1040 E. 33/0	l St. Apt 40	6 106	f. Zip Code 2/2/8	1	Og. Citizen of What Co	Ī	
ter death with	Funeral	11. Marital Status 1 Never Married 2 Mari	ited 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No		ecedent of Hispanic Origin? specify Cuban, Mexican, Pu		14. Race - Ame White, etc.	erican Indian, Black,	
5-0036 led within 72 hours aff Hygiene. other than "natural" the Medical Examins	Completed by	15. Decedent's Education (Secoit	or Dates:	16a. Decedent's Us during most of	sual Occupation (Give kind of working life. DO NOT use		16b. Kind of Business	Macriland Naccoland	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examine; must be notified at once	Be Comp	17. Father's Name (First, Middle, Li	ast)	Secreta	18.Mother's N	lame (First, Middle, M		Jarylunu	
- P = E E E	Tol	19a. Informant's Name/Relationship SUSIL Pile 20a, Method of Disposition	Mother	19b. Mailing Add	133rd Street and Number	et Rural Route Num	mber, City or Town, Sta		
MOFE Pages 1 ent of F nt: If i			3 Removal from State cr	rematery or other pl		122/10	Battimon	e Maryland	
		700	emplications that caused the death. I	Vanov	on C. Greene 1	F.S. Buil	imore, Mari	Mand 21212	
Physician /Medical Examiner		/failure. List only one cause or		.iver	orde ordying, such as cardi	ac or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of):):					
cuted md transit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						
760, Totate be executed the burial - transi	Medical	☑ UNPENDED IF FEMALE:	AMENDED #5, per 23a, PII, 27,	perME G90	6/2/10 TT 03 5/25/10 T	Γ	Ond Date of deliver		
x 68;	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unkno	1 Live birth 4 Pregnant at time of deal	2 Fetal de		gnancy	23d. Date of delive Month	Day Year	
P.O. Boy es that the deatl igned by the att			9 Unknown contributing to death but not res	sulting in the underl	lying cause given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?	
ords, P.C w requires that as been signed I	eted by		cardiovascular	disease;	chronic	1 Yes		obably 4 Unknown	
tal Records tian: The law requ certificate has been ector, page 2 should	Completed	alcohol_use			OC Plane of Death (Ch.	1 ✔ Yes 2	sy prior to	completion of cause of	
Vital hysician: this certif	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 🗸 E	ER/Outpatient 3	26.Place of Death (Che	rsing Home 5 1	Residence 6 Othe	er:	
J Of Jing P After funera		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig	(Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No		now injury occurred		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could n 4 Homicide determi		ne, farm, street, fac	tory, office building, etc.	28f. Location (S or Town, St		tural Route Number, City	
To the Hos within 24 h To the Fur completely	Medical		sician: To the best of my knowledge ner:On the basis of examination and and manner stated.						
	Σ	29b. Signature and title of certifier	- ~		29c. License number O.C.M.E.		29d. Date signed <i>(Me</i> May 15, 2010	onth, Day, Year)	
ϕ		30. Name and address of person who Donna M. Vincenti, MD	no completed cause of death (Item 2 Assistant Medical Exami		nn Street, Baltimore,	MD 21201			
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	9					

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2<u>010</u> Physician/ Regina Kay Petty May 14 Medical 4b. City, Town, or Location of Death
Towson 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** Gilchrist Hospice 8. Date of Birth (Month, Day, Sep. 30 . Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Davs 217-62-4444 Months Hours Min. Country) 54 **Director** 1954 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" ----- any injury or other traumatic. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9804 Tailspin Lane #F 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Palmer Helen Mayhew 19a. Informant's Name/Relationship (Type, Print)
Harry Petty Jr./ Husband 19b. Mailing Address (Street and Number or <u>Flural Route Number, City or Town, State, Zip Code</u> 9804 Tailspin Lane #F, Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 4/16/2010 Woodbine,MD Final Journey Crem. ^{22. Name and Address of Fallismation Services}
PO BOX 1413, Baltimore, MD 21203 Signature of Funeral Service Licens Porota Marshall W. lla sunte 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Stoke Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** hupertensin Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumonia 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: A

Be (26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 🗌 Yes 2 🗆 No 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b.	Signa	ture and	title of	certifie	r	
		1)	1	ar	low	
_		100	_			$\overline{}$

29c. License number

29d. Date signed (Month, Day, Year, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVES NO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FFANY Month Day **Physician** 1.54 AM 2010 /Medical 4a. Facility Name of not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗶 F (Month, Day, Year) 11/11/1972 227-21-5100 37 Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at Director MD PG Bowie 1X Yes 2 □ No or 28a-f s notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò be 2155 Vittoria Court 23a items 23a Funeral 20721 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status ural", or iten I Examiner ı Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black þ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MS Teacher Public School 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I tem 27 is marked o Pages 1 and 2 should be Henry V. Reynolds Jeanette P. Penn ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Reynolds / Father 2155 Vittoria Court; Bowie, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State Dale Memorial Park 05/24/2010 Chestfield, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signarule of Funera 4594 Beech Road; Temple Hills, MD 23a. Part 1 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ter the disease, or co Approximate Interval Between shock, or heart failure. List only of Onset and Death Immediate Cause (Final disease or condition resulting in death) emol Physician /Medical r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 25 No signed by the atter Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2T No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 TYes 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\bigcap\) Nursing Home 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 2 □ No 1 Yes death. filled in by the Director: 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide after City or Town, State) within 24 hours a the Hospital 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State

NISHA 31. Date filed (N

AGGARWAL 32. Fee

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

MD

600 North Wolfe St, Baltimore, MD, 21287

Registrar

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 5628 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ratliff Physician/ Day 2010 Year Month Homer 17:50 PM Medical 1av 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death Baltimore Johns Hopkins Bayview Medical (conkr 5. Social Security Number 2 2 8 - 4 0 - 4 6 0 3 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birtny. Co*u*n*try)* <u>WVA</u> **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Min Hours 78 Director 1931 Usual Residence of Decedent fshow 10a. State 10b. County notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River -28a-f 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1 Cowl Court 21220 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 K Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: marked other than "natural", matic event, the Medical Exa White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Parts Procurment Westinghouse Co. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Perry Ratliff Lena Kesner Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Frances Ratliff /son Cowl Court Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 5/20/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signal re f F neral S vice Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician arachnoiv Hemospha disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami CERTIFICATION APPROVED BY MEDICAL TYAMINTO that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, æ 26. Place of Death (Check only one) 1 Yes 2 🗌 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After thi leted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending May 12 2010 Un Known M 1 Tes lesumed Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) At Home Hospital Medical To the Hosp within 24 hou To the Funer completed fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature a 29d. Date signed (Month. Day. Year) RES-000 ss of person who completed cause of death (Item 23a) (Type, Print)

Caldian MD 4940 Baskin Avenul, Baltimore, MD, 21224 O_{\prime} 31. Date filed (Month gistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #L per MD 9904 6/12/10 TT
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Maurice B. Stewart, Sr. 2. Date of Death Date Month 5 3. Time of Death Physician/ 6,20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore n/a 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Director 213-32-6029 M) Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 828 Braeside Road 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Spe African-American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Shock Trauma Executive Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John P. Stewart Isabelle Carev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 828 Braeside Road, Catonsville, MD 21229 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Crystal McCaffity/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-24-2010 Arbutus Meni. Park Arbutus, MD 22. Name and Address of Facility Wile Funeral Hone P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 2 art 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each list he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consenuence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 f yes, outcome of pregnancy

☐ Live Birth 2☐ Fetal death 3☐ Ectopic pregnancy
☐ Pregnant at time of death 5☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ failure renal To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, To Be Completed 1 Yes 2 No 3 Probably 4 Unknown fibrilation 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe CHE 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linder Au Balt 40 21201 31. Date filed (Month, Day, Year) 32, Regi a ar's Signature State Registrar

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Physic Med Exam Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

	Pleas	se Type or Printer State of Ma	nt in Black I aryland / Dep			•	_	le.	
	1 - State Registrar 1. Decedent's Name (First, Middle,	(ast)	Ce	rtificate of D	eath	R 2. Date of Deat	eg. No.201	0 15630	
Physician/ Medical	James	Lou	is	Sha		Month MAY	Day Ye	3. Time of Death ar 15:30 PM	
Examiner Funeral	4a. Facility Name (if not institution, s SINA HOSP) 5. Social Security Number	TAL OF BI	ALTIMORE (In yrs. last birthday)	4b. City, Town, or L BALTIM If Under 1 Year	ORE CI		4c. County of E	Death Birthplace (State or Foreign	
Director								ashingtonD.	
3a-f sho iffied at ector	10a. State 10b. County	10b. County 10c. City, Town or Location N/A Baltimore						10d. Inside City Limits 1 Yes 2 □ No	
items 23a or 28a-f she ler must be notified at Funeral Director	10e. Street and Number 4000 Bellevie			10f. Zip Code 21215			U.S.A		
وَ إِنَّا كُو	1 Never Married 2 Marrie	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☑ N			in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-				
iene. It than "natural" the Medical Exa	15. Decedent (Specify only highest	s Education	+) (Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin					
Aental Hygie irked other tic event, tt To Be C	12th Grade 17. Father's Name (First, Middle, La Unk	st)			anitor N/A 18. Mother's Name (First, Middle, Maiden Surname) Geneva Wright				
eaith and N	19a. Informant's Name/Relationship (Type, Print) Dale Dickerson(Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, States 1461 Middletown Rd., Annapolis, N								
tment of H rtant: If ite ijury or oth	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	ecify)		matory or other place Brown F/] matory	05/1	7/10 1	20c.Location - City Baltimo:	ce,MD	
Depar Impor any ir	21. Sign vure of Funeral Service Lie	ne 6-	Roane ?	Joseph H 2140 N.	of Facility Brown Fulton	Jr. Fi	uneral E altimore	Home e,MD 21217	
physician and with the burial-transit and properties the burial-transit and properties and properties are physician examiner.	Exock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a C/R) b. Due to (.r 25 d	ER FAI consequence of): RHOSIS consequence of): ATITIS	LURE.				Approximate Interval Between Onset and Death	
To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but majority of the funeral director. Be Completed by Physician/Medical Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnancy 2 Fetal death 3	Ectopic pregnancy Other (specify)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		23d. Date of Month	1	
Id be detac	Part II. Other significant condition SEIZURE			underlying cause give	n in Part I.			e to the cause of death?	
page 2 should be d	HEPATORE	NAL S	YNDRO	ME		24a. Was ar autops perform	y prior ned2∕ deat	e autopsy findings available to completion of cause of h? Yes 2 2 No	
er this certificate has be eral director, page 2 s	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of injur		nt 3 DOA Other	4 L Nursing Ho	me 5 Reside	ence 6 Other (S	pecify)	
Director: After the in by the funeral Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could not 4 Homicide determin	t be	Year) injury work? M 1 □ Yes 2 □ No ry - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,						
the Funeral mpleted filled	(Check 2 L Medical Ex- only one) 3 Certifying	hysician: To the best of raminer: On the basis of ex purse Practioner: To the b	amination and/or inves	stigation, in my opinion death occurred at the t	, death occurred at time, date and place	the time, date and e, and due to the	d place, and due to t cause(s) and manne	the cause(s) and manner state r as stated.	
9 8	29b. Signature and title of dertifeld	Multiple course of	M. B.	Print\	-000			3, 2010	
State	JUREA Abo	MAITYTE 32. Registra	r's Signatus	INAI HO	SPITAL	OF	BALTI	MORE	
Registrar	MAY 19 2010	flowing 1	a. para						

DHMH 17 Re

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** DOLORES OUL 6:57 AM MAY 2010 7 /Medical 4a Fecility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE- CHARLES STREET BALTIMORE N/A Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1□ M 2□F 214-38-4695 7 Orrs. Director 8-5-1939 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Merylend nant of Heelth end Mantal Hygiene. Int: If Item 27 is marked other than "natural", or items 23e or 28e-f ehow 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County f Heelth end Mantai Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 ehov other traumatic event, the Macilcal Examiner must be notified at MD N/A BALTIMORE 1X Yes 2 □ No Completed by Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 111 W. CENTRE STREET **APT 503** 21201 U.S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE OF MARYLAND Elementary/Secondary (0-12) College (1-4or 5+) DEPT. EDUCATION 12 4 CPA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JAMES** SOUL JOHN ANNA Α. (LOPATA) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10037 36 W. 138th STREET APT 16 NEW YORK, NY 19a. Informant's Name/Relationship (Type, Print)
VERONIKA SOUL/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition BOHEMIAN NATIONAL CEM 5-210 Depertment of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of F e Li nsee 1211 CHESACO AVE ROSEDALE, MD 23a. Part . En et like disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificete be execut Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? TLL Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 70 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No eral Director: After this filled in by the funerel di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a
To the Funeral C
completely filled 29a. Certifier 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Thaw foon, mi 30. Name and address of person who completed 21202 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Charlotte Shupe May วิดี10 10:12 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign (Month, Day, Year) November 4, 1943 1 🗆 M 2 💢 F 212-42-2280 Maryland Director Usual Residence of Decedent or 28a-f show 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Baltimore Dundalk Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21222 2928 Yorkway Apt A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2 No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Robert Tucker Sr. Martha Ei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Daughter 2928 Yorkway Apt B., Dundalk, Maryland Kimberly Ann Shupe Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 20, 2010 Christ Lutheran Cemetery injury (Dundalk, Maryland Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 77110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sclerodurna 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No 25. Was case referred to medical examine?

1 Yes 2 No the Hospital or Attending Physician: the funeral director, Be 26. Place of Death (Check only one) Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred injury Accident 3 Sui-5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200338897 05/18/2010 30_Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimora MD 21224 3700 54 Flest . 55 . A MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4b, per MD & 10c, per Fh g904 6/2/10 TT

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Kevin Lamont Tyler Sr. 1:22A M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6973 Brookmill Road Baltimore **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2-16-1960 1**X** M 2 □ F Months Hours Director 220-74-0961 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 10d. Inside City Limits Baltimore 1 ☐ Yes 2 🌠 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6973 Brookmill Road 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after 21215-0036 African-American 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3
Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Car Sales 12th Antwerpen Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Phyllis Jackson Franklin Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6973 Brookmill Road, Baltimore, MD 21215 Robin Denise Bass/Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5-19-2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 9200 Liberty Road Randallstown, MD21133 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k / r heart failure. List only one cause on each Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 35 330 31. Date filed (Month, Day, Year) 32. Registar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:55 201 Medical acility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death 8. Date of Birth Month, Pay, **Funeral** If Under 1 Year 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 Months Min Director 0 lennessee show 10a. State with the Maryland 10b. County Examiner must be notified at Town or Location 10d. Inside City Limits Director or 28a-f 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, 19a. Informant's Name/Relationship (Ty Method of Disposition 20b. Place of Disposition (Name Burial 2 Cremation 3 Removal from State Remeterv Signature of Fun ral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 은 1 🔲 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed *(Month, Day, Year)*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ρ 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** more 8. Date of Birth (Month, Day If f Ir last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", 3 Divorced Completed Year or Dates Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If Item 27 is marked other than College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 20012 19a. Informant's Name/Relationship (Type, Print) ece. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 2rd 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 7/2010 Department 22. Name and Address of Fa Joseph L. Rus 22.22 W. North Signature of Funeral Service Licenses 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 7 Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending p SS IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Day Month Pregnant at time of death the 9 Unknown P.O. I Unknown ed by t s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy this certificate 2 No 1 Yes **Division of Vital** director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 \square Pending injury work?
1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar W. BELVEDERE AVG.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Tuszynski John Chester May 18 4:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Dundalk Baltimore 7825 St. Claire Lane Social Security Numb 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland Months Days Hours Min (Month, Day, September 216-42-4604 Director 65 Usual Residence of Decedent or items 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Marvland Baltimore Dundalk 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21222 7825 St. Claire Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 item 27 is marked other than "natural", other traumatic event, the Medical Exa 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years **Plastics** Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Joseph Tuszynski Stella Veronica Wiatr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 7825 St. Claire Lane, Dundalk, Maryland Anna M. Tuszynski 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 21, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) any injury or Holy Rosary Cemetery Baltimore, Maryland 2010 21. Signature of Funeral Lervice Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Cell Physician. Concer disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death Yes 2 □ No ed by the a 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco_use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 2 i within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniurv 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signa re and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, ih.D. May 18th. 2010 145390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Nin (M. D.) 9114 Dishadelphia Road # 208 Battinuere. 9114

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra & Signature

			Flease	Type of Pilit in			-	•	
	•		For	State of Marylar	nd / Departm	ent of Health and	d Mental Hy	giene	
			State Registrar		Certific	ate of Death		Reg. No. 2010	15637
			1. Decedent's Name (First, Middle, Las	t)			2. Date of De		3. Time of Death
	Physicia Medic		Donnie Ve	rnia W	illiam	<	Month	120 17	11250
	Examin		4a. Facility Name (if not institution, give			City, Town, or Location of De	eath	4c. County of Deatl	1750
			Good Samo	uritan Ho	soital	Baltimoi		,	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. i	last birthday) If U	nder 1 Year If Under 24 H	lrs. 8. Date of Birt	th 9. Birt	hplace (State or Foreign
	Director		237-42-5795 1	XM2□F 76	Yrs. Mon	ths Days Hours M	in. June	Z4 1933 No	rth Carolina
	3		Usual Residence of Decedent				OWIC	21110110	TIT CHI CITING
	and sho	ρ	10a. State 10b. County	10c, Cit	ty, Town or Location				10d. Inside City Limits
	Mary 8a-f tifie	ec	MD	[·	3altim	ore			1 🟋 Yes 2 □ No
	the or 2	۵	10e. Street and Number			. Zip Code		10g. Citizen of What Co	untry?
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	517 Lynhur	st Stron	e +	21229		115	4
	ems ems	Ľ.	11. Marital Status	12 Was Decedent Ever in III	S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer	ican Indian.
2) 0	er de or it	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give			erto Rican, etc.)	Black, White	
. ~ S	saft ral", Exa	þ	3 Widowed 4 X Divorced	If Yes, Give Year or Dates,	1 □ Y	es 2 🔀 No Specify:		Specify:	lack
onnie 215-0036	72 hours after n "natural", o Aedical Exami	Completed	15. Decedent's Ed			Usual Occupation		16b. Kind of Business I	ndustry
0n 215	n 72 an "	Ē	(Specify only highest gra Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give kind or life. QO NO	work done during most of w use retired)	vorking	, ,	
7 2	withi giene er th		12	00110g0 (1 4 01 04)	Lat	porer		Loadin	9 WOCK
Z D	lled oth vent	Be	17. Father's Name (First, Middle, Last)				lame (First, Middle,	Maiden Surname)	/
a a	ld be 1 Menta arked atic ev	욘	Donnie Lee	William	15	\mathcal{R}_{0}	50 W	orthu	
Maryland	should and N is ma aumal		19a. Informant's Name/Relationship (T)	· · · · · · · · · · · · · · · · · · ·		ress (Street and Number or		r. City or Town, State, Zio	Codel
	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental hygiene. ontant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.		Dannie L. Will	ams (Son)		Voodridge T	$\gamma = 1 \circ 0$	altmore N	1D 21229
ج ق آ	l and f Hea item othe		20a. Method of Disposition	20b. F	Place of Disposition	(Name of	Date	20c. Location - City or	
mo m	Page ment or ant: If ury or		1 Burial 2 Cremation 3 C	Removal from State	cemetery, crematory	A \		0 1	
Willia altimore,	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Specifical Service License)		Uthy ore		25-10	Baltimor	
6 Ba	permi Depar Impol any ir once			11	Valu	e and Address of Facility		al Service	
			23a. Part 1. Ent the disease, or comp	Situations that says and the deat	515	1 Maitmore	Nation		(Z1ZZ9)
- 10			shock, or heart failure. List only or	ne cause on each line.	III. Do not enter the t		4	A .	Approximate Interval Between Onset and Death
-	Physician/		Immediate Cause (Final disease or condition	a Atherosch	evotic (bronary 1	vascula	1 disease	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequent		89			
		声	Sequentially flat conditions,	Huperte	MSION				
8.	p #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence)	1	at Dath			
170	and trans	xar	Cause (Disease or linjury that initiated events	c. Congesti		nt tallar	<u> </u>		
0-	be executed sician and burial-transit	calE	resulting in death) Last	11 4	2 1	· A			
09	ate b shysic the b			d. Halber 11	<u> Jidemi</u>				
387	eath certificate b attending phys d for use as the I	×	IF FEMALE:	20- 16					
×	th ce ttend or us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live Birth 2 Feta	al death 3 🗌 Ecto	pic pregnancy		23d. Date of deli	- /
Bo	dea the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of a 9 ☐ Unknown	death 5 🗌 Othe	r (specify)		Month	Day Year
Division of Vital Records, P.O. Box 6876	at the	Physician/Med	Part II. Other significant conditions of	entributing to death but not res	culting in the underly	ing cause given in Port I	00 8:44		
σ.	s the	Completed by		structive				obacco use contribute to	~ /
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5	aw re as be 2 sh	ple	arrial tibr	illation			24a. Was autor		opsy findings available ompletion of cause of
Re	The la ate h	No.	1					rmed? death?	2 □ No
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ξ	nysic lis ce direc	은	1 ☐ Yes 2 ZHO	Hospital:	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Resid	dence 6 Other (Speci	fy)
of	ig Piter th		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		low injury occurred	
on	ath. r: Afr	ica	2 Accident Investigation		,а.,	1 Yes 2 No			
<u>isi</u>	er de recto by th	Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ctory, office		Street and Number or Run	al Route Number,
Ο̈́	tal or			building, etc. (opecin)	, 		City or Tow	m, State)	
	ospi hou uner	dica	29a. Certifier 1 X Certifying Phys	ician: To the best of my know	ledge, death occure	d at the time, date and place	, and due to the car	use(s) and manner as sta	ted.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of examination e Practioner: To the best of m	y knowledge, death o	ccurred at the time, date and	place, and due to the	e cause(s) and manner as	stated.
	To t		29b. Signature and title of certifier			29c. License number		29d. Date signed (Month	, Day, Year)
			100/0	ell, mi	>	D00627	35	may . 11	2010
	,0		30. Name and address of person who c		23a) (Type, Print)				/
_	14		Aparna Jonn	almo 5	601 600	h Raven B	olva, B	altimore	MD 21231
	Stat	е	31. Date filed (Month, Day, Year)	32. registrar's Signar	ture	6 0	,		
	Registra	ır	MAILUZU	10 Lawrence	A. Alask				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Henry Lucurtis White May 2010 Medical 1640 p 4a. Facility Name (if not institution, give street and number) **Examiner** 4h. City Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton PG . Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ Hours Min Director 1070971944 North Carolina 237-72-3191 65 Usual Residence of Decedent or 28a-f show notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Oxon Hill 1X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 4615 Wheeler Road Examiner must 20745 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify:Black "natural", 3 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) the th and Mental Hygien 27 is marked other the traumatic event, the Distributor Washington Post Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cornelius White Mabel Slade t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley L. Tyson-White/ Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 4615 Wheeler Road, Oxon Hill, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Cemetery 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/22/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? assarb After this certificate 2 🗌 No Yes Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 40 1 Tes ည 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c, Injury at work? 1 \(\sum Yes\) 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation within 24 hours after death To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖵 🗲 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Chata	partment of Health and Me Pertificate of Death	ntal Hygiene Reg. No.2010 15639
Physician	1. Decedent's Name (First, Middle, Last) Charles Frederick Waring	2.	Date of Death Month Day 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4	208 South Paradise Ave. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	Catonsville	Baltimore
Funeral Director	5. Social Security Number 219.26.7712 6. Sex 1 ☒ M 2 ☐ F 7. Age (In yrs. last birthda) Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
pug *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		uly 26,1938 Maryland
Maryle Fr sho	,		10d. Inside City Limits 1 □ Yes 21 No
und 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. do other than "natural", or items 23a or 28a-f show event, ithe Medical Evantines must be matified at Be Completed by Funeral Director	10e. Street and Number 208 South Paradise Ave.	10f. Zip Code 21228	10g. Citizen of What Country?
r death tems 23 cr num	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricc	Yes or No- 14. Race - American Indian,
21215-0036 d within 72 hours after gjene. er than "natural", or in the Modes Evarual Completed by F	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2 ▼No Specify:	Black, White, etc. Specify: White
15-C	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
21215-0 ed within 72 hou lygiene ner than "natura t, the modelet	Elementary/Secondary (0-12) College (1-4or 5+) I 2	lephone Tech.	At&T
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantment must be notified at once. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname) 1iller
Mary nd 2 sho atth and 1 27 is ma r trauma	19a. Informant's Name/Relationship (Type. Print) 19b. Mail		oute Number, City or Town, State, Zip Code) Catonsville, Md 21228
more,	20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 20b. Place of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State		20c. Location - City or Town, State
Baltir Dermit. F Departme mportan any injur	4 Donation 5 Dotter (Specify)		ing Ashton Schwab Witzke sville, Inc.
132.00	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	630 Edmondson Avenue	: Catonsville, MD 21228
Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	show to leakering	Interval Between Onset and Death
/Medical Examiner	resulting in death) a. Due to (or as a consequence of):	may re le vici miy	(years
iner sit se V	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
b, of seecuted an and rial-transit	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
5876 icate be physicia the bu	d		
the death certified death certified to the attending ched for use a sysician/Me		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
HECOTGS, he law requires to a has been signed ge 2 should be or mpleted by	Cerebral reminhage		1 ☐ Yes 2,☐ No 3 ☐ Probably 4 ☐ Unknown
I Ke The la ate has bage 2			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
OT VITAL Physician: T this certifical ral director, p	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outnatien	26. Place of Death (Ch	
on or ding Phys h. After this tuneral dir	1	4 Traising Home	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
LIVISION (tal or Attending F is after death. al Director: After led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director. All completely filled in by the fun	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, deat 2 □ Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and vestigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)
New thin Comp comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	> 75um 1, Muzul Atender Mysicin		May 14, 2010
5	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1
State Registrar	Bruce R. McCurdy, MD. 716 Maiden 31. Date Red (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	Choice Lane Suite 10	Balto. MD. 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04730/2018 Year KATHY PATRICE ADDISON 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Days Min. Months Hours 09/16/1963 Director 214**-**90-6250 46 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7616 Laytonia Drive 20877 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1X Never Married 2 ☐ Married 2 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Certified Chef Hebrew Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Nathaniel W. Addison, Sr. Violet Louise Isreal injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Addison - mother 7616 Laytonia Drive, Gaithersburg, MD 20877 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 2 XCremation 3 - Removal from State emetery, crematory or other place) 1 🗌 Burial on 5 Other (Specify) 4 Dona ent Cremation Svc: 05/04/10 Hanover, MD 21. Signature of Funeral Service Lic Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or conshock, or heart failure. List only nications that caused the dene cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final 2ºnsabrithish Physician/ Toxoplasmosis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 9 years End stage AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the bunal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pancytopenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No 2 XNo Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) HOSPICE 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending thours after death.

uneral Director: Afted filled in by the fur 1 Yes 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check 3 🗆 To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

Litle of certifier

Joseph Puthumana 31. Date filed (Month, Day, Year)

MAY 05

Gurman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

82. Registrar's Signature

D47123

201 E. University Blvd, Baltimore, MD 21218

29d. Date signed (Month, Day, Year)

5/1/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 04/28/2010 THOMAS LEE ALBRIGHT 8:40 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cherry Hill Nursing Center Prince George's Laurel . Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 02/16/1945 Director Yrs 243-70-8685 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 Kes 2 No MD Prince George's Lanham 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a must be Funeral 10019 Greenbelt, #303 20706 USA 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White etc. 6 Completed by 1 Never Married 2X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12th Horse Trainer Private Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jerry Lee Albright Annie Lee Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 9346 Canterbury Riding, Laurel, MD 20706 Denise G. Albright - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or ol once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 Donation 5 Other (Specify) 5/7/10 Zion UMC Cem. Laurel, MD Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer of the Pancreas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or i that initiated events -tran Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year ☐ Pregnant at time of death ☐ Unknown ed by the 9 Unknown Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed After this certificate has been si funeral director, page 2 should I Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: ¹ 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛛 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 52 0/10

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of Adebowale

31. Date filed (Month, Day, Year)

6201 Greenbelt Rd, #M18, College Park, MD 20740

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Isaac Ajayi

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month De Jesus 2010 Maria Aponte April 9:03 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign $\frac{\text{(Month, Day, Year}}{\text{ug. 5, }}$ Days Months Hours Director Yrs Colombia 579-82-8966 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Montgomery Chevy Chase ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be with Funeral 20815 5500 Friendship Blvd., # 1218N United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No Specify: South American Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Hispanic the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Housekeeper Private Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Transito Bernardo Mesa Aponte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Aponte/Sister 11563 Sullnick Way, Gaithersburg, Maryland 20878 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St Anthony Cem. 5/8/2010 Falmouth, MA. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonain disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Cancer months Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examin Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ģ in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛭 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No မ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending s after death.

I Director: Afted in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 To the I only one) Certifying Nurse Practioner: Is the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of 10 D62553 2010 of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Patsy McNeil, 31. Date filed (Month, Day, Year) State MAY 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Day} 2010^{Year} Month 3:08 Robert B. Bederson \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours April 26,1924 Director 86 NewYork 125-14-0085 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Kensington Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20895 3333 University Bld. Apt 508 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō Completed by Black, White, etc. 1941 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify. 3 ₩ Widowed 4 Divorced 1946 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Lithographer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Bederson Lillian Rosenblum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Bederson/Son 3102 Kent Street, Kensington, Maryland 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o Santing are mater for other place)
Abraham and Sarah Department of 1 Burial 2 Cremation 3 Removal from State May 4, 2010 Paramus, New Jersey 4 □ Donation 5 ☒ Other (Specifyntombment 22. Name and Ad Dangamsky-Gollberg Memorial Chapels, Inc 21. Signature of Funeral Service Licencee M01597Melissa Greenhut 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner rinary Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Atherosclerotic ovener ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year 2 No 9 Unknown that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ō, Completed by The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? 2 🔀 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 20 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 old Georgetaun 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 04 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ap Maril 26, Day 010 Year 1945 рм Ansonja Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital 6. Sex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Min. Sept. 21, Hours 1 □ M 2 🕅 F Months Country) C. 1978 Director 578-56-8483 31 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. sant; If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince Georges Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 2921 Brownstation Road U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 X Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Day Program Spec. Ed Day Program Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ansonja M. Thoms Clifton Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2640 Bowen Road, SE Washington, DC 20020 Tracy McCrimmon (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important; If any injury or once. Chesapeake Crematory 05/07/2010 Beltsville, Md. 4 Donation Other (Specify) ignatu Funeral Sen ²² Warnend Agress of Facility ineral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010 Inter the disease, or complications that caused the death or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death hysician/ newholopati **HODE** Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 4/2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pa1500 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes <u>ا</u>و 2 ER/Outpatient 3 DOA 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Tate of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natura 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D0063998 4127 110 less of person who completed cause of death (Item 23a) (Type, Print) esh Nachnani, M.D. 7503 Suratts Rd., Clinton, Md. 20735

31. Date filed (Month, Day, Year) Registrar

Manesh Nachnani,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar	,	Certif	icate of	Death		Re	eg. No.	
Physicia Medical Examir	n/	Decedent's Name (First, Middle		l Wayne	e Clar	k		2. Date of Deat Month May 13, 20	Day Year	3. Time of Death 0925 hrs
		4a. Facility Name (if not institution 1400 Oak Ridge Park	n, give street and number)		4	b. City, Town, or Hagerstowr		Death	4c. County of Dea Washington	th
Funeral Director		5. Social Security Number 220-64-6535	6. Sex 7. Age 1 M 2 F	(In yrs. last) 55	birthday) Yrs.	If Under 1 Yea Months Days		Min.	th(MM/DD/YYYY) 9. B Fore 6 , 1954	
and show any nce.		Usual Residence of Decedent 10a. State 10b. County Maryland Was	hington	10c. City, To	wn or Locatio		erstown	n		10d. Inside City Limits 1 X Yes 2 No
the Marylan a or 28a-f s		10e. Street and Number 17942 Garden				10f. Zip Code	1740		0g. Citizen of What Co	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo	12. Was Decedent Armed Forces? 1 Yes 2 orced If Yes, Give Year	Ever in U.S. X No	If Ye		, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	White, etc.	rican Indian, Black,
136 hin 72 hours a e. than "natura edical Examis	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12	College (1-4 or 5			's Usual Occupat est of working life. Mechani	. DO NOT us		16b. Kind of Business Auto	/Industry
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygiene. n 27 is marked other than umatic event, the <u>Medica</u>	Be	17. Father's Name (First, Middle, Richard V.	Clark				18.Mother's I	Name (First, Middle, M	Maiden Surname) yser	
e, MD 2 I and 2 should Health and M item 27 is m	2	19a. Informant's Name/Relationsh Wilma E. Clark 20a. Method of Disposition	(Mother)	20b. Plac	1635	Edgewood	l Place		mber, City or Town, Sta wn, Maryla 20c. Location - City of	nd 21740
Baltimore, permit. Pages I ar Department of Her Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify: Licensee	Smit	hsburg 22. Na	g Cremat ame and Address	ory	2010	Smithsbu is Funeral	rg, Maryland Home
	4	23a. Part I. Enter the disease, or	complications that caused	MO141	12:					yland 21783 Approximate Interval
Physician /Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		t Wound		, mode of dying,				Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	quence of):						
ecuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
760, icate be executed tphysician and the burial - transi	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcom	o of prognar	200				23d. Date of delive	nv.
	Physician/N	23b. Was decedent pregnant in the past 12 months?			2 Fet	al death 3 er (Specify)	Ectopic pr	regnancy	Month	Day Year
s, P.O. E nires that the d signed by the	اھ	Part II. Other significant conditi	ons contributing to death	but not resu	lting in the ur	nderlying cause g	given in Part I	1Yes		obably 4 Unknown
Records, P The law requires t icate has been sign	Completed							24a. Was a autop perfor	sy prior to m <u>ed</u> ? death?	utopsy findings available completion of cause of
Vital Rec ysician: The l his certificate l director, page	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 EF	V/Outpatient		O45	heck only one)	Residence 6 🗸 Oth	er Scene
of Ing Ph	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	28a. Date of Inju	ry 28	Bb. Time of In OUND: 919 hrs	jury 28c. Inju	ry at Work? Yes 2 ✔ No	28d. Describe h	now injury occurred	J. 000.10
Divisior Hospital or Attenc 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	d not be mined (Specify) Sto	rage Shed	<u> </u>	t, factory, office b		or Town, S 1400 Oak Rid	tate) ge Park, Hagerstow	
To the Hos within 24 h To the Fur completely	Medical	(Check only Certifying Ph	nysician: To the best of my miner:On the basis of exan and manner stated.				, death occur			he cause(s)
	-	30. Name and address of person	in Level	eath (Item 23	a)	O.C.I			May 14, 2010	,
			ssistant Medical Exa	miner '		Street, Baltir	more, MD	21201		
St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redistrar	's Signature	1 ha	well.				
DHMH 17 Rev 1/20	_	OCME	LUIU LEA		ORIGINAL					

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			For State	State of	Maryland					and M	lental Hy	giene)			, m
	-		Registrar	(4)		Cer	tificat	e of D	eath			Reg. No	.2 ()		1564	6
	Physicia	in/	1. Decedent's Name (First, Middle, L	,							2. Date of De Month May	ath 09	1y 20	ÝPar 10	3. Time of Death 9:00 P M	4
	Medic		Harold Wayne Cl		er)		4b. City	Town or	Location o	f Death	мау	7	. County o		9:00 F N	_
زر	Examin	ier	302 Quaker Creel		.,		,	cock	Location o	Death			ashin			
	Funeral			. Sex 7.	Age (In yrs. la	st birthday)	If Unde	1 Year			8. Date of Bir	th		g. Birthp	ace (State or Foreig	n
	Director		219-44-3932	1 🔀 M 2 🗆 F	6	52 Yrs.	Months	Days	Hours	Min.	May 28	y, Year)	47	Count	MD MD	
	d d	_	Usual Residence of Decedent 10a. State 10b. County		100 City	. Town or Loc	etion							L	Od. Inside City Limits	_
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	or 28; notij	Director	10e, Street and Number	ngton		Harreo	10f. Zip	Code			1	10a Cit	tizen of Wh	nat Count		
	with t	eral	302 Quaker Cree	k				1750)			109.01	USA		. , .	
	tems er mu	Funeral	11. Marital Status	12. Was Decede			Vas Deced	lent of His	spanic Orig	in? (Spe	cify Yes or No-		14. Race	- America	ın Indian,	
ဂ္ဂ	ifter d ", or i amin	by	1 Never Married 2 Marrie	Armed Force d 1 ☐ Yes 2 If Yes, Give			Yes			, Puerto I	Rican, etc.)	1		White, e		
0500-C17	ours a ntural al Ex	Completed	3	Year or Date	s.								Specify:	Whi		_
<u>n</u>	72 handan ma	현	15. Decedent's (Specify only highest	grade completed)		16a. Deced (Give F		k done di	ition uring most	of worki	ng	16b. K	ind of Bus	iness Ind	ustry	
7	vithin giene. er tha the l		Elementary/Seconday (0-12)	College (1-4	or 5+)	Labor		700700)				Co	nstru	ctio	n	
ğ	filed val Hyg	Be	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden	Surname)			
yland	ld be Menti arke atic e	욘	Stewart Clinger	rman					Ethe	l Je	rome					
Mar	shou rand raum		19a. Informant's Name/Relationship			1	_				Route Numbe	-			•	
G,	and 2 Health em 2; ther t		Richard Clingerr	nan/Son	00h DI				Road		fordsb					
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3		ate ce	lace of Dispos emetery, crem	natory or c	ther place	:		ate		ocation - C	-		
	nit. Pa artme ortan injun		4 Donation 5 Other (Special Signature Funeral Service Lice		Buc	k Vall			aL 0.				ords		, PA	_
Ď	permit Depar Impor any in once.		1 (56	A 1	M00260					1 4	l West P.A.Har				0-0368	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that cau	sed the death										Approximate	
P	ใญจาดเล่า/	0.1	Immediate Cause (Final disease or condition	y one cause or each	-/1-	Herry	Dise	ese							Interval Between Onset and Death	
لر	Medical Examiner		resulting in death)	a	as a c nseque	ence of):		-						_		-
		ř	Sequentially list conditions,	b. —										\perp		_
	sit sit	mine	if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to lor	as a conse pue	ence of										
	ecute and l-tran	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):								+		_
>	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. Of the Funeral after death. To the Funeral after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner		d.												
	ficate g phy as the	1 O I	IS SENAN S	u								- 1				
00 4	n cert tendin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnan th 2 🗆 Fetal		Ectopic p	regnancy	/				23d. Date	of delive		
ָבָּאַ מַבְּי	v requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown		nt at time of de		Other (sp						Monti	h I	Day Year	
5	at the d by t etach	Phy	Part II. Other significant conditions	s contributing to deat	th but not resu	ulting in the u	nderlying	ause give	en in Part I.		23a Did to	phaceo ii	se contrib	uto to the	cause of death?	_
, ,	res tha signer	d by	, a	.7		-1.1.1g 11 11 10 10	iaan, ing	g			1 🗆				ably 4 🗆 Unknowi	n
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5	ig Ph ter thi neral		27. Manner of Death	28a. Date of		28b. Time of injury		Bc. Injury work?	at		8d. Describe h			opeayy		_
	endin eath. or: Afi he fur	fica	1 Natural 5 Pending 2 Accident Investigat	tion	Day, roar,	ii ijui y	М		/es 2 □	No						
2 :	or Att fter de irecte n by t	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of	Injury - At honetc. (Specify)		et, factory	, office		2	28f. Location (S City or Tow			or Rural F	Route Number,	
5	of the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s		29a. Certifier 1 Certifying P	hysician: To the best	of my knowle	alaa daath o	soured at	the time			t don to the co	(-)				_
:	24 hc 24 hc Fun eted	Medical	(Check 2 L Medical Exa	miner: On the basis ourse Practioner: To	of examination	and/or investi	igation, in	ny opinior	n, death occ	curred at	the time, date a	nd place	, and due to	the caus	se(s) and manner stat	ed.
:	vithin To the comp	2	29b. Signature and title of certifier	1	and book of my	Kilowicago, a		. License		ана ріаск			e signed (/			_
			> / Vlather H	talin M.	D.		D	560	48			Mar	12,	2010		
			30. Name and address of person wh		of death (Item :	23a) (Type, P	.1									
			131 North Pennsy		ue, Ha	ncock,	Mary	land	2173	D						
	Stat Registra		31. Date filed (Month, Day, Year)	2010 32. R/9i	istrar's Signatu	Jre A	arte	1								

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amend items 18, 19a per inf g905 7-16-10 yr.

State of Manyland Department of February Mental Hygiene

AMEND TEMP Reper File Copy 1, 7 1 1 1 2 2 1 1 0 ms. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 7:45 PM Diane Crafton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospita] Lanham Prince Georges If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F (Month, Day, Year) Months Davs Hours Min. **Director** 577-66-4239 /30/194 Wash Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD P.G. Glenarden 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 8635 Mclain Ave. 20706 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State Department Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moss Daisy Mae Butler မ Joe Butler 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other tratonce. Landrus C. Crafton Jr. 8635 Mclain Ave. Glenarden, Md. 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/10 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. Suitland.Md. 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards Hill Rd.Suitland Md.20746 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Breast Onset and Death Physician/ Concel disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Lisease or imjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? To the Funeral Director; After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🖯 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good/oes fromise Prive, Bowie Hlexander 12700 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 7/2009

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 4 IOMEI 7310 1628 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CROFTON CARE & REHABILITATION CENTER CROFTON ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min MAY 30 Director 579-16-2832 T921 WASHINGTON, DC 88 Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2159 SCOTTS CROSSING COURT,# 103 21401 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 X Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 SELF-EMPLOYED DRY CLEANERS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve မ GEORGE A. CIOMEI HATTIE ELIZABETH KOONTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE EILEEN CIOMEI/WIFE 2159 SCOTTS CROSSING COURT, # 103, ANNAPOLIS, MARYLAND 20a, Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE) CREMATEON 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State MAY 3, 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2010 STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Will E Bowe M00672 23a. Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Beath Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed Cause (Disease or linjuly that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 XW eted cause of death (Item 23a) Type; State

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Registrar

Baltimore,

68760

Box

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ Day Connelly Cary 2010 5:27 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min 9/237 1956 220 70 Mary Land 9249 53 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d, Inside City Limits Director 1 ☐ Yes 2 🌠 No Howard County Marvland Jessup 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20794 8687 Pine Tree Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married I Hygiene. other than "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Retai1 any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Henry Hunter Houchens Lydia Ann Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is Lydia A. Buckler/Mother 2804 Cedar Dr. Riva, MD 21140 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Page 1 and Department of H 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem'l Gardens 5/5/2010 4 Donation 5 Other (Specify) Davidsonville, MD of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatura ala 2973 Solomons Island Rd. Edgewater, MD 20735 Pa 1. Enter the disease, or comshock, or heart failure. Ist only ear ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Gastrointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cirrhosis that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hepatitis Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Completed Hyponatremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending 1 X Natural Division 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) I gmilie Cobert, MD resident physician 1497980510 May ,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Greene St., Baltimore, MD. 2/201 Cobert Emilie 31. Date filed (Month, 32. Registrar's Signature Registrar

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State of Maryland / Department of Health and Mental Hydiene

		•	1 - State Registrar	State of Maryland	-	tificate of L			gierie Reg. No 2010	15650
	Physicia	n/	Decedent's Name (First, Middle, Last) ELSIE	COOPE				2. Date of Dea Month APRIL	nth Day 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s		χ	4b. City, Town, or	Location of Death	APKIL	4c. County of Dea	9:00 P M
n +2				ENTER NURSING			ANHAM			GEORGE'S
	Funeral Director		5. Social Security Number 467-22-7985 Usual Residence of Decedent	7. Age (In yrs. lat	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEB I		irthplace (State or Foreign ountry) AS
	land show dat	tor	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f	irec	DC	WAS	SHINGT					1 X Yes 2 □ No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 53 BUCHANAN STREE'	TNE		10f. Zip Code	20011		10g. Citizen of What C	ountry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fune		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 MNo If Yes, Give Year or Dates.	l I	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 X No	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5-0	r2 hour	plet	15. Decedent's Edu (Specify only highest grad			lent's Usual Occup kind of work done o	ation during most of work	ing I	16b. Kind of Business	s Industry
2121	within 7 giene. er than ;, the Mo	Com	Elementary/Seconday (0-12) 12TH	College (1-4 or 5+)	life. Do	O NOT use retired)	VE ASSIS		GOVERNME	ENT
land	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) GEORGE HANKS				18. Mother's Nam	e (First, Middle, M WHITAKE	•	
, Maryland 21215-0036	d 2 should ealth and M 1 27 is ma er traumal		19a. Informant's Name/Relationship (Typ SHA RON KELSEY/GR.				and Number or Rura		City or Town, State, ZRYLAND 207	
Baltimore,	Page 1 an ment of He tant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State ce	metery, cren	sition (Name of natory or other plac ON NATION	øj 1≱L 5/6/		20c. Location - City o	1ARYLAND
Balt	permit. Depart Import any inj		The sum of	е	1	. Name and Addres	•		KINS FUNE R,MARYLAND	
	Physician Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death cause on each line. COLON CANC Due to (or as a conseque	. Do not ente					Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	CLOSTRIDIUM Due to (or as a conseque		ICILE COI	LITIS		70.	
0	ificate be executed g physician and as the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
. Box 68760	ath certific attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	ac. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	olivery Day Year
s, P.O.	res that the dec signed by the a	<u>م</u>	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	o the cause of death?
ecord	e law require has been si ge 2 should l	Completed					_	24a. Was al autops perfori	n 24b. Were at	utopsy findings available completion of cause of
<u> </u>	sician: The la certificate ha irector, page 2		25. Was case referred to medical			26. Pla	ace of Death (Check	1 Yes		s 2🏋 No
Ž	Physician: this certific ral director,	욘	1 □ Yes 2 □ MNo	ospital: 1		t 3 □ DOA Othe	r: 4 💢 Nursing Ho	me 5 🗆 Reside	ence 6 🗆 Other (Spec	cify)
o uc	ding th. After fune	icate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 🗆		28d. Describe ho	w injury occurred	
Division of Vital Records,	tal or Atten Its after deal al Director: led in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	iral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L Medical Examine	cian: To the best of my knowled er: On the basis of examination of Practioner: To the best of my l	and/or investi	gation, in my opinio	 n, death occurred at 	the time, date an	d place, and due to the	cause(s) and manner stated.
	To the Total		29b. Signature and title of certifier	, M.D.		29c. License	number 063978	2	9d. Date signed (Mont	h, Day, Year) 2010
	8		30. Name and address of person who con			*	י ייי די די די די די די	MADVI AND	20770	
	Stat		HINA SYED M.D. 7	32. Registrar's Signatu			EENDEL1,	MAKI LANL	20//0	
	Registra	r	MAY 0 5 2010	Cerem B. A	William					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 3, 2010 Day Mary O'Briant Clampitt 6:44 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7114 Edgevale Street Chevy Chase Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 415-42-5011 1 □ M 2 🗓 F Months Days Hours Min (Month, Day, Year Feb 18, 1931 **7**9 Mississipoi Director Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Montgomery 1 Yes XX No Chevy Chase 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 7114 Edgevale Street 20815 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. ģ 1 Never Married 2 X Married 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White "natural", Specify: 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Program Analyst permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumair. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theron Russell O'Briant Ola Bell Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Clampitt, Jr. /Husband 7114 Edgevale Street, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory May 4, 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd W, Silver Spring, MD 20901 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic colorectal cancer disease or condition resulting in death) vears Medical Due to (or as a consequence of): Examiner Pleural effusions 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year g Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2XX No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pendina n 24 hours after deau...
The Funeral Director, Aft 2 Accident work? 1 Pes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ctifie

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

H. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

04

Gisell Mery MD, 6000 Executive Blvd, Suite 302, Rockville, MD 20852

Registrar's Signature

29c. License number

D59244

29d. Date signed (Month, Day, Year)

May 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month April 29 <u> Annabel Londner Chasen</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Chevy Chase</u> 4601 North Park Ave. #51 <u>Montgomery</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days Months Hours Min (Month, Day, Year) 09/14/192 **Director** 220-38-1793 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 North Park Ave. 20815 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 4 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Isadore Londner</u> Faye Shulman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Chasen / Son Clarden Road Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem. Park | 05/02/2010 Falls Church, VA Signature of Funeral Solvice Licens 22. Name and Address of Facility
Danzansky-Goldberg Memorial C
1170 Rockville Pike Rockville MO1477 Chapels Kurt Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia <u>3 Days</u> Medical Due to (or as a consequence of) Examiner Advance Vascular Dementia 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy Yes 2X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury 2 No Accident Investigation 3
Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicinar To the basis of my in collection and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at ctated. (Check inly and Signature and title 29d. Date signed (Month, Day, Year)

State Registrar Narhe and address

Μ. 31. Date fi Month, Day, Year)

Wiseman

04

erson who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

12890 (DC)

5410 Connecticut Ave. NW, Suit 117, Washington DC 20015

April 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year MAT MARGARET COLE 4 8:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 5422 85th AVENUE # 201 NEW CARROLLTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days SEPT 25 Min **Director** 95 WASHINGTON.DC 577-60-5603 1914 Usual Residence of Decedent items 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

To is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Medical Examiner must be notified at. 10a State 10c, City, Town or Location 10d. Inside City Limits Directo 1 TyrYes 2 No MD PRINCE GEORGE'S CARROLLTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5422 85TH AVENUE # 20784 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No If Yes Give 3 X Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH MONEY EXAMINER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WESLEY MORGAN NUGENT ETHEL. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code item 27 5422 85TH AVENUE # 201 NEW CARROLLTON, MD 20784 DORIS WORMLEY /DGT. or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, injuny o RIVERDALE CREMATORY 5/6/2010 RIVERDALE, MARYLAND 21. Signature of Funeral Sen J. B. JÉNKINS FUNERAL HOME ce Licensee 22. Name and Address of Facility on a 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ DEMENTIA Medical Due to (or as a consequence of): Examiner ADULT FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialphysician Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ę in the past 12 months? Pregnant at time of death Month Day Vear 1 Yes 2 Leg Unknown detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed 2 should be de 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page I or Attending Physician: The I after death. Director: After this certificate h performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital of within 24 hours a To the Funeral D

Hospital

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

9200 BASIL COURT # 200 LARGO, MARYLAND 20774 IVAN ZAMA M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) **NAY 0 6 2010**.

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#18. PerFHPCC5-11-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 PETER DICKENS May 0439 A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday)
74 Yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days January 11, Year) 1936 North Carolina 1 **X** M 2 □ F Director 240-54-0509 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 X Yes 2 ☐ No Montgomery 10e. Street and Number 10g. Citizen of What Country? 20902 USA 12117 Edgemont Street . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after 1 ☐ Yes 2X No Specify: Specify: Black "natural", Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 6th College (1-4 or 5+) Montgomery County School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Mack Dickens Rosie Bell Bynum Rosie Bell Dickens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is 12117 Edgemont Street, Silver Spring, MD 20902 Viola J. Dickens - Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 8, 2010| Tarboro, North Carolina East Lawn Cemetery 4 Donation 5 Other (Specify) 21, Signature of Funeral School Censee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ RESPIRATORY FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner SEVERE RESPIRATORY DISTRESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami PANCREATIC CANCER death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No Physician; The 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No Hospital: Other: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 K Natural injury 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3 22 47 2-10 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Nooshin Farr, MD, 1500 Forest Glen Road, Silver Spring, MD

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

MAY 0 5 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea . For	ase Type or Print in State of Marylar				_		gible.	
	-	State Registrar		Cer	tificate of D	Death		Reg. No.?	110	15655
Physicia: Medic		Decedent's Name (First, Middle DORET			DAVIS		2. Date of D	_{eath} L 28 ^{0ay} 201	0 ^{Year}	3. Time of Death 9:30 P M
Examine	•	4a. Facility Name (if not institution, SOUTHERN MARYL	AND HOSPITAL			CLINTON		PRINC	y of Death E GEO	RGE'S
Funeral Director		5. Social Security Number 577-06-3760 Usual Residence of Decedent	6. Sex 1 \square M 2 \boxtimes F 7. Age (In yrs. 43	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth av, Year) 30 1966	9. Birthpl Counti WASH	lace (State or Foreign rv) INGTON, DC
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	10a. State 10b. County MD PRINCE 10e. Street and Number	E GEORGE'S	ty, Town or Lo	HILLS 10f. Zip Code			10g. Citizen of		0d. Inside City Limits 1 AYes 2 No try?
	≦	4607 DALLAS PI 11. Marital Status 1 Never Married 2 XMarrian Status 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No	ı	Was Decedent of Hir f Yes, specify Cubar □ Yes 2X No	n, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - America ick, White, e /: BL	
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permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra ance.	1	20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Removal from State	cemetery, cren	sition (Name of natory or other place TION CEME		Date 8/2010	20c. Location	•	
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ath certificate be attending physici for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	al death 3 C death 5 C	Ectopic pregnanc			М		Day Year
requires that the de been signed by the should be detached	2	Part II. Other significant condition	ons contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		tobacco use con	_	e cause of death? ably 4 Unknown
n: The law re ficate has be or, page 2 sho	Completed	25. Was case referred to medical			OC DIA		1 🗆 Yes	opsy ormed?		sy findings available npletion of cause of 2 🔣 No
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ending Pt eath. or: After th the funeral		27. Manner of Death 1 Matural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	28b. Time of injury	28c. Injury work? M 1 🔲	at ? Yes 2 🗆 No	28d. Describe	how injury occur	red	
To the Hospital or Attending Physician; The is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		4 Homicide determ	ined 28e. Place of Injury - At no building, etc. (Specify	v)			City or To	Street and Numb wn, State)		
the Hosp thin 24 ho the Fune impleted fi	Medical	(Check 2 Medical E	Physician: To the best of my know examiner: On the basis of examination Number Practioner: To the best of m	n and/or invest	igation, in my opinio	n, death occurred time detalend pla	at the time, date	and place, and du to cause(s) and to	e to the caus	se(s) and manner stated
5 × 5 0		250, Signature and the or certifier			1	3209		29d. Date signe	_ '	**
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State Registra	-	31. Date filed (Month, Day, Year) MAY 0 8 2010	32. Registrar's Sign	ture ak				300		

DHMH 17 Rev 7/2009

10-03336 Branden Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	U	Dt	כ כ
Certificate of Death			

Control Description			1- For State Registrar			Certific	ate of	Death			Re	eg. No.			
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Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	0 1		30 Name and address of hereon	who completed car	se of death	(Item 23a)									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Conzalez 17:00 PM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOPKINS Bayview Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Sept.15,1980 **Funeral** Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min. 216-69-0088 El Salvador 29 Director Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10b. County ıral", or items 23a or 28a-f sho I Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🄀 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 El Salvador 3900 Weller Rd. 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", White Completed 3 Widowed 4 Divorced Salvadorian Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Gonzalez Diaz Rosaibel permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Francisco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Weller Rd., Silver Spring, MD 20906 German Rodriguez / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of 5/20/2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Heaven Cem. Name and Address of Facility app Funeral and Cremation Services 933 Gist Ave. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: , nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year signed by the a d be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page performed certificate I 2 No Yes 2 No 1 Tes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 | No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signa 29c, License number D67406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Hoesch, MD, PhD 4940 Baskin Avenue, Baltimore, MD, 21224

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28 Day 2010 ar Aprit 6:05 a N John Diggs 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 3 9. Birthplace (State or Foreign Year 934 Months Days Hours Min. Country) Virginia 1 1 M 2 □ F 226-48-8351 75 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits D. C. Washington Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2576 Naylor Road, S. E. 20020 U. S. A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 🕅 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. **Black** Specify: 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bricklayer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Diggs, Sr. Rose Geniva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Johnson (Daughter) 2576 Naylor Road, S. E. Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation Removal from State Chesapeake Crematory 05-15-2010 Beltsville, Md. 4 Dopation 5 ☐Other (Specify) 21. Si ature & Fuperal Service Name and Address of Facility
H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, DC 20010 Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypotension Intractable Due to (or as a consequence of) Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): rod pneumonia and sepsis resulting in death) Last Acute Renal feiture IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIV related bone narrow suppression, syphilis, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown on ventilator and tracheostomy, 24b. Were autopsy findings available prior to completion of cause of death? typoalbuminenia, Diabetes, G.E. Bleed, Anenia, (Bjenoral) 1 Dyes 2 No
25. Was case referred to medical examiner?

26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ö 23a

or items

"natural"

marked other than

Department of Health Important: If item 27 any injury or other tr

F Health and Mental Hv.

Pages 1

72 hours after

Baltimore, Maryland 21215-0036

event, the Medical Examinar must be notified at

Director

Funeral

ş

Completed

Be

law requires that the death certificate be executed the burial-tra use as

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Jenniter

29b. Signature and title of certifier

2200 mdi MD

MAY 0 6 2010

6 Could not be

Hospital or Attending Physician: The funeral director this After t within 24 hours after death To the Funeral Director: filled in by

Division of Vital Records, P.O. Box 68760,

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 68005

Objadi, MD, 7600 Carroll Avenue, Takona-Park, MD 20912

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 02. Deutsch 2010° Rhoda 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Hours Min. July 18. **Director** 578-42-5141 New York Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2209 Newton Drive 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates Caucasian the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Janko Rose Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith B. Deutsch - Daughter 6020 California Circle, #212, Rockville, MD 20852 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 05/06/2010 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Quantico Natl. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD 20904 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Atherosclerotic Coronary Artery Disease Medical Due to (or as a consequence of **Examiner** Aortic Valva Stenosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Diabetes, Hypercholesterolemia. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Acute Myocardial Infarction, Ventricular Fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred

sician and burial-transit The law requires that the death certificate be executed attending physician for use as the burial Box 68760 the P.O. þ signed to Division of Vital Records, peen has this certificate director,

should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho.

and 2 s Health a

Maryland 21215-0036

Baltimore,

or 28a-f shov

Hospital or Attending Physician: n 24 hours after death.

e Funeral Director: Af To the Hosp within 24 hou To the Funel completed fil

28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

29c. License number D56845

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 05 2010

Kathleen Petro. 7610 Carroll Avenue. #440. Takoma Park. Maryland 20912 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death R Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Day Year **Physician** Jains eth Or 30 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rd mont Sprin Silver Pomer hel 8. Date of Birth (Month, Day, Jan. 23, 9. Birthplace (State of Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 KF 214-80-5920 52 Director Usual Residence of Decedent with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ir then "netural", or Items 23e or 28e-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 15510 Layhill Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 2 should be filed within 72 tand Mental Hygiene.
Is marked other then "net (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paralegal permit. Pages 1 and 2 should be file Department of Health and Mental Hys, Importent: If Item 27 is marker or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Lewis Taylor Evelyn May Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen A. Hope/Sister 1502 Dublin Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Alexandria, Virginia 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Þ 500 University Blvd. W., Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DHYXI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 10 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pendina self-inflicted UNK A 1 ☐ Yes 2 No death. investigation Apr 30 2010 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide filled in by determined 4 Homicide suc o Silver Soving, mo To the Hospitel o within 24 hours aff To the Funerel Di 20906 29a. Certifier 1 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier mo oms 30,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 N. BRETHOS wo owe 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 4 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	partment of Health are ertificate of Death	1	Reg. No: UIU JOOI
.	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Jean Yetta GELF 4a. Facility Name (If not institution, give street and number)	AND 4b. City, Town, or Location of to Rockville		30, 2010 30, 2010 4c. County of Death Montgomery
	Funeral Director		Hebrew Home of Greater Washington 5. Social Security Number $129-01-0870$ 6. Sex $1 \square M$ $2 \mbox{T}$ 7. Age (In yrs. last birthda, Yrs.	y) If Under 1 Year If Under 24	4 Hrs. 8. Date of Bin Min. April 2	9. Birthplace (State or Foreign Country) New York
	e Maryland le-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Roce Maryland Montgomery Roce	kville		10d. Inside City Limits 1 □\rightarrow es 2 □ No
	3a or 28	I Dire	10e. Street and Number 6105 Montrose Road	10f. Zip Code 20852		10g. Citizen of What Country? United States
136	d within 72 hours after death with the Maryland jiene. In than "naturel", or Items 23a or 28e-f show The Medical Evantrat must be Lodiffed at	by Funeral Director		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F □ Yes 2 No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-61212	N 0 0 0		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation ve kind of work done during most of DO NOT use retired) Homemaker	of working	16b. Kind of Business/Industry Own Home
yland	be file tal Hy d othe event,	To Be C	17. Father's Name (First, Middle, Last) Sam Schneider		s Name (First, Middle, SSie Forma	
Mar	and 2 should ealth and Men n 27 is marke er traumatic			iling Address (Street and Number Tournament Dri		
nore,	t of H		1A Burial 2 Cremation 3 Memoval from State	position (Name of rematory or other place)	Date 05/03/	20c. Location - City or Town, State 2010 Falls Church, VA
Baltimore,	permit. Par Departmen Importent: any injury once.		21. Signature of Puning Service Licensee MOIDOS	22. Name and Address of Facility Orchinsky Hebre 254 Carroll St.	w Funeral	Home
/60, (te be ysicially see burne to b	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Interval Between Onset and Death
O. Box 68	death certif e attending od for use a	Physiclan/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
1	uires that the de signed by the a Id be detached I	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 □ Probably 4 □ Unknown
I Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed			24a. Was auto perfo 1 Yes	
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Othon	of Death (Check only		
o	ding Phys	atlon: To	1 Yes 2 No 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe	idence 6 Other (Specify) how injury occurred
Division	# O O -	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Rural Route Number, wn, State)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de description on the description of the de	ath occurred at the time, date and investigation, in my opinion, death	d place, and due to the h occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
)	12		mires Juli	D00648	71	4-30-2010
			30. Name and address of person who completed cause of death (Item 23a) (Type Mina Fazli, mD 1801 E. Jeffer	rson St., Rockvi	11e, MD 2	20852
••	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 82. Registrar's Signature	del		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /Month o GRAY CARMEN 10845am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Months Hours Min (Month, Day, Year) 19<u>35</u> OHIO Director 283-30-6013 75 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 29a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S HYATTSVILLE 1 H Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5108 72nd PLACE 20784 IISA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hyglene. Important; If item 27 is marked other than "nestron" any injury or other than 1 Never Married 2 Married Black, White, etc. If Yes, Give Year or Dates 1 Yes 2 X No Specify. BLACK 3 🗌 Widowed 4 🔲 Divorced Specific 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
LEOLA THOMAS CLARENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH GRAY/HUSBAND 5108 72ND PLACE HYATTSVILLE, MARYLAND Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 5/6/2010 RIVERDALE CREMATORY RIVERDALE, MARYLAND of Theral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Jevere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trans Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No ģ Pregnant at time of death Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy erformed? this certificate 1 XYes 2 🗌 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ္ 1 🔲 Yes 2 No Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c . Injury at 28d. Describe how injury occurred i Natural 5 Pending work? 1 🔲 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. MDD 52865 2010

Registrar
DHMH 17 Rev 7/2009

State

Tigaro, mD. 12700 Goodloes Promise Dr., BowlE, MD. 20720

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael

Day, Year

elson

filed (Month.

MAY 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 27, Day 2010 Year Edwin Bernard Harriday 5:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)
Washington, D.C 219 46 9495 Director 61 Feb. Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Germantown 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19529 Gunners Branch Road, Apt. 20876 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. <u></u> 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Midowed 4 Divorced Specify: Black Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the <u>Maintenance Man</u> Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Unknown Unknown Saddie Harriday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si F Health a tem 27 is Phyllis Carroll/Sister 18451 Brooke Road, Sandy Spring, Maryland 20860 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important; If ite any injury or of o <u>∓</u> 1 Burial 2 M Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Dongtion 5 ☐ Other (Specify) Chesapeake Cremetory May 10,2010 Beltsville, Maryland 21. Signature of Funeral Service Acens 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, obcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Respiratory Acidosis Sequentially list conditions, it any leading to immediate cause. Enter Underlying Drei to for as a consequence of Exam attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hypothermia Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ☐ Pregnant at time of death☐ Unknown ed by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No upleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 \square Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar DD066656

9901 Medical Center Drive, Rockville, Maryland 20850

April 27, 2010

akeye

Oluwapelumi O.

31. Date filed (Month, Day, Year,

MAY 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fakeye,MD

82. Registrar's Signature

Samuel Harding		State of Maryland / De		f Health and Menta	al Hygiene	201	0 1566		
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	RDING		2. Date of Dea Month May 1, 20	Day Year	3. Time of Death 0033 hrs		
		4a. Facility Name (if not institution, give street and number) 6831 Riverdale Road Apt. D2		4b. City, Town, or Location of Riverdale		4c. County of Deat Prince Georg			
Funeral Director		212-31-3988 ₁ M ₂ ₂ 55	rs. last birthday) Yrs	If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Br. 11/16/	inth(MM/DD/YYYY) 9. Bi /1954 Forei	rthplace (State or gFREETOWNE TEKRA LEONE		
Maryland 28a-f show any d.at.once.	or	Usual Residence of Decedent 10a. State	City, Town or Locat				10d. Inside City Limits 1 X Yes 2 No		
with the Maryland ms 23a or 28a-f sho be notified at once.	al Director	10e. Street and Number 6831 RIVERDALE ROAD #D2 11. Marital Status 12. Was Decedent Ever in	011 S 142 We	10f. Zip Code 20737		USA			
r death	by Funeral	1 X Never Married 2 Married 1 Yes 2 No. 3 Widowed 4 Divorced or Dates:	o 1	(E)	uerto Rican, etc.)	White, etc. Specify: B1	CACK		
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 5+		nt's Usual Occupation (Give kir lost of working life. DO NOT us		16b. Kind of Business/	Industry		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) BOIMA M. HARDING 19a. Informant's Name/Relationship (Type, Print)	19h Mailing	JANE JANE G Address (Street and Number		ŕ	Zin Codo)		
Baltimore, MD 21215-0 pernit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the I	Ť	REGINA HABIB/SISTER 20a_Method of Disposition 20	7511	WILHELM DRIVE)6		
Baltimore, permit. Pages I an Department of He Important: If ite			GATE OF H		J. B. JE	SILVER SPE			
Physician /Medical:		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ath. Do not entér th sclerotic Cardi		TOURN T ON	TED MADVIANT			
	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a of):						
execu an and al - tra	dical	UNPENDED AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executally the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transparence.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pr 1 Live birth 4 Pregnant at time of 9 Unknown	2 Fet	tal death 3 Ectopic poner (Specify)	regnancy	23d. Date of delivery Month	Day Year		
s, P.O. uires that the n signed by the detache	ত্র	Part II. Other significant conditions contributing to death but no Diabetes Mellitus	ot resulting in the u	nderlying cause given in Part	1 Yes		pably 4 Unknown		
of Vital Records, ig Physician: The law require that the this certificate has been sineral director, page 2 should be	Completed				1 ✔ Yes	prior to death?	topsy findings available completion of cause of es 2 No		
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Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined (Specify)	_	t, factory, office building, etc.	or Town, S				
To the Hos within 24 h To the Fun	Medical	Check only 2 Medical Examiner: On the basis of examination and manner stated. 29b Signature and title of certifier	edge, death occurr and/or investigati	red at the time, date and place ion, in my opinion, death occur 29c. License number	and due to the caus	e(s) and manner as state and place, and due to th 29d. Date signed (Mor	e cause(s)		
CP 3		30. Name and address of person who completed cause of death (Ite Laron Locke MD. Assistant Medical Examine)	,	O.C.M.E. Street, Baltimore, MD	21201	May 1, 2010			
Sta Regist	ate	31. Date filed (Month, Day Year) ASSISTANT Wiedical Examine 32. Registra's Signi		——————————————————————————————————————					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b per FH G904 6/15/10 dk

State of Maryland / Department of Health and Mental Hygiene 5665 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Hays Howell 2010 10:00 P M May 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1005 Accokeek Road Waldorf Charles If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F 90 Director October 4,1919 Scotland 157-05-6862 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Prince George's 1 ☐Yes 2X No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Accokeek Road 20601 Funeral Scotland 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: 9 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unobtainable Unobtainable 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Accokeek Road, Waldorf, Maryland Frank Hays Howell/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐Removal from State /7/2010 Metropolitan Crematory 4 Donation 5 Dother (Specify) Alexandria, Virginia of Funeral Service Licensee any In 22. Name and Address of Facility Jefferson Funeral Chapel 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5755 Castlewellan Dr., Alexandria, Virginia 22315 Immediate Cause (Final Alzheimers Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 1 ☐ Yes 2 ER/Outpatient 3 DOA P 1 Inpatient 5 ■ Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760,

show

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

within 72 hours after

s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th

Department of Healt Important: If item 2 any Injury or other Pages 1 s

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Baltimore, Maryland 21215-0036

e Hospital or Attending n 24 hours after death.

ne Funeral Director: A
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29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17 (0 (0 (0 (0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Ct. Donna Leskuski, M.D. Upper Marlboro, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 0 6 2010 **ORIGINAL**

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRITZ **HAFENRICHTER** April 1 20¥0 8:00A. 30° Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Hospice Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) 79 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 578-50-9702 1 🛛 M 2 🗆 F Days Hours Oct 17 7 2 1930 Director Germany Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 🗆 Yes 2 🖹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15301 Wallbrook Court, #2E 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. rmed Forces?
No Yes 2 No Black, White, et ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates, 1956-1957 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ramp Supervisor United Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paulus Hafenrichter Martha Vetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trat. LaVerne Hafenrichter -wife 15301 Wallbrook Court, #2E Silver Spring, MD. 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State George Washington Cen. 5/5/2010 1X Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V: Borgwardt Funeral Home, PA Dovalel 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Chronic Obstructive Pulmonary Disorder disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Dus to for seas a nonsequence of; if any leading to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed? Yes 2 No certificate 1 Yes 2 XNo 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) ပ္ 1 Tes 2 No Other: 4 Nursing Home 5 Residence Other (Specify) within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending iniury 2 🗆 No Investigation Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 10 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60634 April 30, 2010 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 Bindu Joseph,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

05

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 04727/2010 SHIRLEY LOUISE HOLLAND 12:55 A Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Hours 12/03/1935 Yrs Director 577-50-3195 74 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 15423 Doveheart Lane 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. o 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced Black al Hygiene. d other than "natura event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Child Care Provider Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Charles Mason Mary Johnson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11115 Cherryvale Terr., Beltsville, MD 20705 Karen Holland-Norris - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buria 2 X Cremation 3 Removal from Sta 4 🗌 Dg ion 5 Other (Specify) Ardent. tremation Sv 5/5/10 Hanover, MD 21. Signat of Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 26a. Part 1. Enter the dise cations that caused the death not enter the mode of dying, such as cardiac or respiratory arrest, se, or comp Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition Onset and Death Brain stem hemorrhage Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner High blood pressure Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Examiner July to (or as a ponsequence cry Diabetes Cause (Disease or linjury that initiated events and as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Chronic kidney disease - stage 5 The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year led by the detached 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sate has been signing page 2 should be Completed 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No မ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

2

only one 29b. Signar

Lee Schwabb

31. Date filed (Month, Day, Year)

MAY 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ach

1500 Forest Glen Road, Silver

32. Registrar's Signature

29c. License number

Spring, MD 20910

D22990

29d. Date signed (Month, Day, Year)

04/28/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Collins Donne 11 Jenkins April 28 2010 9:50 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice/Casey House Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Min Hours 423-62-0514 Director 62 Alabama April Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3412 Robey Terrace; Apt. 201 20904 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: Black. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ! Hygiene. other than " Elementary/Seconday (0-12) other traumatic event, the Landscaper Landscape Gardening 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jenkins, Sr. Carrie Melinda Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pennie Sherell Griffin (niece) 3412 Robey Terrace; Apt. 201; Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. Sonature of Fu eral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street,N.W.;Washington,D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month g Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has page 2 s autopsy death? certificate 2 **X** No 2 🗌 No 1 Yes Yes Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: မှ 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after deat Director:

Baltimore, Maryland 21215-0036

funeral director, Certificate: (Month, Day, Year) 1 X Natural 5 Pending Accident
Suicide 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie eted 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 1 within 2 To the 1 complex only one) 29b. Signature and title of certifie Missers

29d. Date signed (Month, Day, Year) April 29, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP;6001 Muncaster Mill Road; Rockville, Maryland 20855 Nicole Christenson; 32. Registra s Signa

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Lorrathe 500 213 OIC 20/0 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 923 SILVAL DV m 22 1 30 = Omer If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 1 □ M 2 1 F Months Days Hours Min 217-46-9985 63 Director 01/24/1947 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exactions and be notified at Director 1 X Yes 2 No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 7923 Eastern Avenue, #701 20910 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify Specify: 3 ☐ Widowed 4 💆 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) Extramural Research Analyst of Health 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Waverly Woodson Joann Snowden ည permit. Pages 1 and 2 should Department of Health and MM Important; If item 27 is mark any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damia E. Jackson - daughter 10360 Royal Woods Court, Gaithersburg, MD 20886 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial → Marcremation 3 Removal from Sta 4 Donation Ardent 4/23/10 5 ☐ Other (Specify) Cremation Svc Hanover, MD 21. Signatury Funeral Service Lie 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? P 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 2 Accident 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Division of Vital Records,

the death certificate be executed and the burial-tra attending physician for use as the buria ned by the a signed I page 2 should has certificate Physician: this After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

r than "natural", the Modical Exa

7 is marked other traumatic event, I

Baltimore, Maryland 21215-0036

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State

Registrar

Medical

3 🗌 Suicide

29a. Certifier

29b

4 Homicide

(Check only one

Signature and title of certifie

22. Registrar's Signature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner:—On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

OME

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31. Date filed (Month, Day, Year) 05

6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M A Wonth 2010 1722 PEARL Μ. KINS 2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST MONTGOMERY HOSP. ROCKVILLE Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 393-10-3588 1 🗆 M 2 🗶 F Months Hours Min. 99 Director WISCONSIN T911 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE 1 Yes 2 □ No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9701- VEIRS DRIVE 20850 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No , or Black, White, etc. 1 Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 No Specify: Specify: WHITE "natural", If Yes Give 3 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than anti-Elementary/Seconday (0-12) College (1-4 or 5+) NURSING NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
BESSIE H. KINS မ ALBERT J. KINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Belleview Drive, Severna Park, Md. 21146 JOHN A. SPENCER- NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State METROPOLITAN CREM 5/3/2010 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Jel 2222-WISCONSIN AVE., NW HYSONG CO. WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition RESPIRATORY FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner HYPOTENSION Faculations list nor ellicasification, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗓 No ည 1 🗌 Yes Other: 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending injury Accident Investigation 6 Could not be 2 🗌 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the only one best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur ertifier License number

cr 4

State Registrar 31. Date filed (Month, Day, Year)

NAY 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2010 April P^{M} 28, 7:45 Grady C. Lane 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charles Charlotte Hall Veteran's Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year Hours Days Months 1**℃** M 2 □ F Carolina 20, 1921 N. 89 Apr. 579–18–2184 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Prince George's University Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 USA 6504 44th Ave. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Xes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ∐Yes 2 ZXNo 3 Widowed 4 Divorced Year or Dates: 1944-46 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Fence Installation Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sally Conyers Wyatt Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6504 44th Ave., University Park, MD 20782 Doris E. Lane / spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/1/2010 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced disease or condition resulting in death) Due to (or as a consequence of): Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): memica resulting in death) Last Due to (or as a consequence of): IF FEMALE: NA 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hyperli autopsy performed 2 □No 2 No 1 □Yes conotio 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

earal Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760,

Division of Vital Records,

the Hospital within 24 hours a

permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 1 once. or other

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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2

Funeral

Director

show

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the World Event and the mailied at

12 should be filed within the and Mental Hygiene.
7 is marked other than "r

. 1 and 2 should be the Health and M

Pages 1

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Certification: To Be 27. Manner of Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Tes 2 **□**/No

> 5 ☐ Pending investigation 6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Natural

3 Suicide

2 Accident

4 Homicide

1 L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 1 hobords

THIBIN

MD

SANTHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 0064324 29d. Date signed (Month, Day, Year) 29 2010

State

Medical

31. Date filed (Month, Day,

, 100 Hospital Rd, Prince Frederick, MD, 20678 32. Registrar's Signature

Dark

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30, D2/010 Mattie Lou Long 2:00P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Magnolia Nursing Center Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Pril 1, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 262-30-3302 1 □ M 2 😾 F Alabama 97 1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Prince George's Lanham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9322 Edmonston Road #104 20770 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2▼ No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 ☐ No If Yes, Give Year or Dates: Black 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook 7th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Malachi Augustus Patton Ella Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vernice Branch (Daughter) 9322 Edmonston Rd, #104, Greenbelt MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc 05/11/2010 Hanover, MD of uneral Service License 22. Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, its Marical Experiment be notified at appear.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events

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_	a.	Severe Cor
r		Due to (or as a consequence of):
	b.	Advance
		Due to (or as a consequence of):
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		Due to (or as a consequence of):
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who completed cause of death (Item 23a) (Type, Print)

1 2	
ysician/Me	IF FEMALE: 23b. Was dec in the pa 1 □ Yes 9 □ Unk
by P	Part II. Other
Completed	
To Be	25. Was case examiner? 1 ☐ Yes
Certification:	27. Manner of 1 Natura 2 Accide 3 Suicid 4 Homic

29b. Signature and title of certifier

resulting in death) i	Lasi	Due to (or as a consected)	quence of):					
IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 0 9 □ Unknown	pronths?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of de Month	llivery Day Year	
Part II. Other signif	ficant conditions co	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?	
					1 \(\triangle \) Ye	s 2. No 3 □ F	robably 4 Unknown	
					24a. Was al autops perforn 1 □ Yes 2	neg4? death?	utopsy findings available completion of cause of	
25. Was case referrexaminer?				26. Place of	Death (Check only on	e)		
1 Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 DAursi	ng Home 5 ☐ Reside	ence 6 ☐ Other (Spe	ecify)	
27. Manner of Death	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		w injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	28f. Location (St. City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	/sician: To the best of my kniner: On the basis of examinated and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and on, in my opinion, death	place, and due to the cooccurred at the time, do	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)	

State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Р Lerner April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Suburban Hospital</u> <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) 06/09/1953 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F Director 216-66-4854 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 X Yes 2 No Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 23<u>05 Ring Street</u> 20851 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 Never Married 2 X Married Completed by 1 Yes 2 If Yes, Give Year or Dates. timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced White ed other than "natur event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Government 5+ <u>Statistician</u> and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Mond Monroe Lerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once. <u> 2305 Ring St. Rockville, MD 20851</u> <u> Althea Nagai / Spouse</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grdns: 05/03/2010 <u>Judean Memorial</u> 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee Kurt Blake MO1477 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fibrosis ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, oronary Autery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Tet W. Chan 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) APRIL 30, 2010 D 50748 30 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suburban Hospital ICY 8600 Old Gocupetown Rd, Bethosda, MARYLAND let W. Chan, MD 31. Date filed (Month, Day, 32. Registrar's Sigrature State 4 Registrar

30/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 рм Aliene Virginia 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Calvert 8. Date of Birth (Month, Day, Year) Frederick <u>Prince</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Hours Director Dunkirk, MD 577-26-2622 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Calvert Dunkirk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10130 Kirksville Lane 20754 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I and 2 should be filed within 72 f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cafeteria Worker Food Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 0tha Franklin Lydia Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dunkirk, MD Millicent V. Franklin - Niece 10130 Kirksville Lane Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State Lincoln Cemetery 5/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. B401 Bladensburg Road Brentwood, MD 20722 Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exam Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 X No 1 ☐ Yes 2 🛭 9 ☐ Unknown 9 Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism autopsy certificate) Dementia Yes 2X No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛛 Natural injury work?
1 Yes 2 No 5 Pending neral Director: A Investigation 2 Accident
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

CR2

Registrar
DHMH 17 Rev 7/2009

State

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urana.

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

50653

G. SURANA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland		artmen rtificate			ind M	ental Hygi	ene	0	15675
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		al Anarew Sung Yong Lee								May	02, 201		10:10am
	Examir	ner	4a. Facility Name (If not institution, give		•		4b. City,		Location of			4c. County		
			Randolph Hills N 5. Social Security Number 6. S		Age (In yrs. las	t hirthriay)	If Under		Vheato		8. Date of Birth			tgomery
	Funeral Director		-	ØM 2□F	91	Yrs.	Months	Days	Hours	Min.	(Month, Day, 02/21/1	Year) Q1Q	Cou	place (State or Foreign intry) Kohea
			Usual Residence of Decedent		71						02/21/1	717		Norlea
	how		10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Pa-f	cto	Maryland Mont	gomery					Rocki	ville	2			1 ☐ Yes 2 ☑ No
	it to	Oire.	10e. Street and Number				10f. Zip	Code			10	g. Citizen of W	hat Cou	intry?
	eth w	Funeral Director	14643 Bauer						20853				I.S.,	
	er de	nue	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Deced f Yes, spec	lent of Hi ify Cuba	ispanic Orig in, Mexican,	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		- Amer	ican Indian, , etc.
36	rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	76		1 ☐ Yes 2	2 🔯 No	Specify:			Specify:		Asian
8	ture hou	edt	15. Decedent's Ed			16a. Dece	dent's Usua	I Occupa	ation		1	6b. Kind of Bus		
21215-0036	oir 72	Completed	(Specify only highest gra	de completed) College (1-4		(Give life.	kind of wor DO NOT us	k done d e retired	during most ()	of workir	ng			,
213	d with	ĕ	Elementary/Secondary (0-12)	4	01 34)	Busi	ness	Ent	reprev	reur	D.	ry Clea	nin	g/Restaurant
p	al Hy dother	Be (17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle, M	aiden Sumame	9)	
Maryland	Ment Ment arked	2	Ukn								Jungso	o Kim		
lar	2 sh		19a. Informant's Name/Relationship (1.						l Route Number,	-		
6	and feelth m 27 her ti		Nancy Owens - Da	ughter						rive,	Silver	Spring Oc. Location - 0		
Baltimore,	ges it of F		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	ale		sition (Nam natory or of		- 1	U			•	
井	it. Partmer rtant njury		* 4 □ Donation 5 □ Other (Specify	1							4/2010 0			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23e or 28e-1 ehow sny injury or other treumatic event, the Modical Examiner must be notified at ODCs.		21. Signature of Funeral Solvice Licen	al days	#145									Home, Inc. 1g, MD 20904
	Americal Medical Medical Medical Examiner Transit Tran	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	Maras as a consequer as a consequer as a consequer	nce of):			` .					Onset and Death
P.O. Box 68	the death certific by the attending p eched for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∐ Fetal de it at time of deat	ath 3	Ectopic pre					23d. Date Mon		/ery Day Year
ds, P	uires thei signed b	ρ	Part II. Other significant conditions o	ontributing to deat	th but not resulting	ng in the u	nderlying ca	ause give	en in Part I.			_		the cause of death?
Vital Records,	e law requir has been si ge 2 should I	Completed									24a. Was an autopsy	PI	rior to co	opsy findings available ompletion of cause of
		ပ္ပိ									perform 1 Yes 2		eath?	2 □ No
Zi.	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only one			
7	Phyer this ral di	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	. 1 □ Inb		VOutpatien Bb. Time of		^	477 IANI		ne 5 ☐ Resider 8d. Describe hov			ify)
on	iding th. th. After funer	ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Day Year)	Injury	м	Bc. Injury Work 1 □ \	k? Yes 2∐N			.,_ ,		
Division	or Attending ster death. Director: After in by the fune	Certification:	3 Suicida 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						2	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	. To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medicai Ce	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the be niner: On the basi and manner	s of examination	edge, death	occurred a	at the tim in my or	ne, date and pinion, death	place, a	nd due to the cau	use(s) and mar te and place, a	ner as	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	/)	1		29c.	License	number		29	d. Date signed	(Month	, Day, Year)
	7		6 Dan AD	Joan	a 1/211	11		1	D5226	1		May (12.	2010
	1		30. Name and address of person who	completed cause	of death (Item 2	3a) (Type,	Print)			•			-,	
								ier s	Spring	, Mo	vryland	20906		
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	6	Ket.				vryland			
	Registr	ar	MAY 05 201	Clerke	u p.	Maria								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 645 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3910 Commander Georges Date of bill... (Month, Day, Year) Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. 1 M 2 T 579-58-2028 65 **Director** Washington, D.C ugust Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Maryland Prince Georges Hyattsville 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3910 Commander Drive 20782 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: 3 Divorced 4 Divorced SpecifAfrican American Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+Special Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Davis Martha Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Commander Drive, Hyattsville, Maryland 20782 Marvin Lindsay/Hushand 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) May 6,2010 Beltsville. Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Boat Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

**The law requires that the certificate has been signed by the attending physician and the content of the sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month ☐ Pregnant at time of death☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes the Funeral Director: After this certific mpleted filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b, Signature and title of certifi 29c. License number 1438 on pleted cause of death (Item 23a) (Type Print) Name and address of person who 445 FENSE 31. Date filed (Month, Day, Year)
MAY 05 2010 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND Item 2 State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Everett M. Lyles 2. Date of Death Physician/ ^{Day}2010 Year Month 3 08:19aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Tokoma Park 4c. County of Death Examiner Washington Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Aug 15, 1927 New Jersey 227-24-4914 82 **Director** Usual Residence of Decedent fshow should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shot raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville Md. P.G. 1 XYes 2 No 10e. Street and Number 10f. Zip Code 20712 10g. Citizen of What Country? 3001 Queens Chapel Road apt208 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Very Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 46-47 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Private Company Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Joseph M. Lyles Alice Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zin Code) 916 Eastern Ave. N.E.#303 Wash.D.C.20019 Dana E. Stewart-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 😾 Burial 2 □ Cremation 3 □ Removal from State May 14, Cheltenham, Md. Cheltenham Veterans 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee P3C3 620001. N.W. 22. Name and Address of Facility Wash. Home Robinson Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown completed filled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown has been STROKE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【▼No 24a. Was an autopsy performed a Yes 2 X HYPERTONSIN After this certificate I 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 500 RIE MAY 3, 2010 D 40324

State

Registrar

7600 CARROLL

AVENUE

TAKOMA PAKK, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registry 's Signe ur

IERMY JODRIE, WD, FACED

31. Date filed (Month, Day, Year) **RAY 0 6** 2010

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		•	For State Registrar	0.0.0	a. ,	•	tificate of			Reg. No.	201	0 1	567
ì	Physicia		Decedent's Name (First, Middle, L BRUCE	ast) WALTO) INT	MA	SLAND		2. Date of De Month	eath Day	2010		ne of Death
ł	Medic Examir		4a. Facility Name (if not institution, g		71/	PIA		or Location of Deatl	May	1	County of Dear		40 P
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	Funeral Director		212-74-04//	. Sex 1 X M 2 □ F	e (In yrs. las 79	st birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Bir 2/18/	1931	9. Bir Ne	untry)	ate or Foreign
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	or 286 notif	Dire	MD. Har	ford		_	10f. Zip Code	allston		10a. Citi	zen of What Co	<u> </u>	700 11 23 110
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	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show dedical Examiner must be notified at		11. Marital Status 1 □ Never Married 2X Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Vas Decedent of f Yes, specify Cul ☐ Yes 2 1 N	Hispanic Origin? (Spoan, Mexican, Puert lo <i>Specify:</i>	oecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit Specify:		
Baltimore, Maryland 21215-0036	~ ~ ~	Completed by	15. Decedent' (Specify only highest Elementary/Şeconday (0-12)	Education grade completed) College (1-4 or 9	lucation de completed) 16a. D. (G. College (1-4 or 5+)			cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)			nd of Business	nore	
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and	be filed ental Hy ked oth c event	일	Floyd A.	Mas	land				arlott		Ruff		
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Balti	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Vic	In Turk	711	22	Name and Add	ress of Facility E	.G. Ku arrett	rtz svil	& Son	Fune	eral
s on	Ph _. sician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	omplications that cause y one cause on each lin	d the death. e.	. Do not ente	er the mode of dy	ring, such as cardiac	or respiratory a	rrest,			imate Between and Death
ممدوا	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
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Box 6876(e death certificate by the attending physic hed for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown								23d. Date of delivery Month Day Year		
, P.O.	s that the igned by be detacl	þ	Part II. Other significant conditions	s contributing to death t	out not resu	Iting in the u	nderlying cause	given in Part I.			se contribute to		of death?
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ita	sician certifi irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		70		Place of Death (Che	ck only one) Iome 5 ☐ Res		V 21 (2	TOC	DICE
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Certificate:	3 Suicide 6 Could no 4 Homicide determin	t be 280 Bloco of Ini					and Number or Rural Route Number, te)				
ш	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of a lurse Practioner: To the	examination	and/or invest	tigation, in my opi	nion, death occurred	at the time, date	and place,	and due to the	cause(s) and	d manner stated
	To the within comp	2	29b. Signature and title of certifier	28ANP				19797_			e signed (Mont)
	•		30. Name and address of person wh	no completed cause of c	leath (Item	23a) (Type, F	Print)	111			// \ 	-	
							LEY RD.	TIMONIU	M, MD	<u> 21093</u>	<u> </u>		
	Sta Registr		31. Date filed (Month, Day, Year)	010 Le Megistr	ar's Signaty	10	A FROM						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Salvadore H. Monico 1922 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death . SALISBURY HICOMICO PENINSULA REGIONAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Hours 4777777925 85 218-18-5775 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Pittsville 1 Tes 2 No Wicomico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 34756 Main St. 21850 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married X Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cable Splicer Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frances Rizzo Angelo Monico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Monico / wife 34756 Main St., Pittsville, MD 21850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State Easter Shore Vet.Cem.: 5/6/2010 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home . Signatur of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Munknown PULMONARY AYPERFENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🔂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAY 20 +1 hodnicki MD

State Registra<u>r</u> 32 Registrar's Signatur

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar				Cei	rtificate o	f Death		F	eg. No.				
		1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea Month	th Day	Year	3. Time o	_	
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amin		4a. Facility Name (If n			4b. City, Town	or Location	of Death		4c. County of Death						
		Laurel	Regio	nal Hos	pital			Laur			Pr	,	Georg		
neral		5. Social Security Num	1	ex 7.Ag □M2XTF		st birthday)	If Under 1 Year Months Day		24 Hrs. Min.	Date of Birth (Month, Day	1	9. Birth	place (State Intry)	or Foreign	
ctor		045-20-2048 87 Yrs OCT. 2 1922										SOUT	TH CARO	DLINA	
		Usual Residence of Decedent 10a. State											City Limits		
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ther	- 22	MICHAEL MARTIN/SON 1000 WHITELE MYZECE IMPZZI,										tion - City or T	own State		
any injury or other traumatic event, ill. Madical Evantime must be notified at once.		1∐ Burial 2 □ 0	Cremation 3 🗆	Removal from State				i				•			
and .		4□Donation 5□Other (Specify) HARMONY CEMETERY 5/7/2010 LANDOVER										R, MARYLAND			
any		21. Signature of Tune	rar Service Licen	see			. Name and Ad						L HOME 2078		
		23a. Part 1. Enter the	disease or comm	alications that causes	the death					LANDOV		KILAND	· · · · · · · · · · · · · · · · · · ·		
		shock, or heart f	failure. List only	one cause on each lir	ne.					or respiratory an	Col,		Approxima Interval Be Onset and	tween Death	
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pe d		Part II. Other significa	ant conditions c	ontributing to death b	ut not resul	ung in the u	ideriying cause	given in Part	1.			contribute to		Unknown	
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e 2 s	24a. Was an autopsy prior performed? dea								24b. Were aut prior to o	topsy findings completion of	s available cause of				
performed? dea 1 □Yes 2 No 1 □								death? 1 ☐ Yes	2 X No						
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23b. Was decedent pregnant in the past 12 months? In the past 12 mon									cause(s) a	nd manner as	stated.	, ,			
									red at the time, o	late and p	ace, and due	to the cause	(S)		
COM	Ž	29b. Signature and titl	e of certifier	1				ense number			29d. Date s	signed (Month	- 4	15	
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•		30. Name and address	ν,	completed cause of d	leath (Item	23a) (Type,	Print)	730		n Duse		d, Lo	aurel,	MD	
			leisman,	1 1	arel f	region	nal Hos	pital,	Eme	ergency	De	pt.	2070	7	
Sta		31. Date filed (Month,		32. Registr	ar's Signati	ire					'				
gistr	al	MAY 05	2010 /4	energy P.C.	ga										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#10e. PerFHPGC5-11-10cr Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 16:05 ^{P м} 2010 DELORES MOORE Μ. 1 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X Days Hours April 29 Washington, DC 72 578-52-3640 1938 Director Usual Residence of Decedent show 10a. State within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10b. County 10c, City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20020 1327-¥ Street, SE USA "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black 3 X Widowed 4 Divorced Year or Dates and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Prather Annie Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 Marlboro Pike, Forestville, Md 20747 Princess Nicholson - Daughter Department of Health Important: If item 27 any injury or other to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 05/10/2010 Suitland, Maryland Vashington National 4 Donation 5 Other (Specify) 22, Name and Address of Facility Johnson & Jenkins Funeral Home . Signature of Fun 12 3 to icensee 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ģ in the past 12 months? Pregnant at time of death page 2 should be detached a I Inknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate metabo 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be B examiner? Hospital: P 1 🔲 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MAY 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Day 9:15 pm 02 2010 Laura Matten Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington 9. Birthplace (State or Foreign Country) New York | If Under 1 Year | If Under 24 Hrs. 8, Date of Birth | Months | Days | Hours | Min. | (Month, Days) | MCCh 24 Social Security Number **Funeral** 1 🗌 M 2 🕱 F 069-16-6281 89 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 20852 U.S.A. 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Confidential Sec & Bookkeeper Office Management Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 7 is marked o ဂ္ Tess Bernstein Beniamin Katz Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Robert Hyams - Nephew 6416 Utah Avenue. NW. Washington, D.C. 20015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o of 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State Wellwood Cemetery 05/04/2010 Pinelawn, New York 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Ducito (or as a consequence of, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ w 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? After this certificate has 1 🗌 Yes 2 🗌 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical

State

Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

min

31. Date filed (Month, Day, Year)

Fazli,

04

Fark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6105

2. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in the population of the basis of examination and/or investigation, in the population of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 5-3-2010

29c. License numbe

D006487

MontroseRel Rockville Mi)

April 30. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:37am Moses B. Middleton 16, April 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Silver Spring Montgomery 1582 East West Highway, 9. Birthplace (State or Foreign Country)
South Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** July 24, 1926 Days Hours 1 ₺ M 2 🗆 F Months Yrs. 83 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It o Medical Examinar must be retitled at 10d. Inside City Limits 10a, State 10c. City, Town or Location 10h. County 1 ☑ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20910 1582 East West Highway. #232 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1946 −
If Yes, Give
Year or Dates: 1948 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify African-American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Middleton Hattie Coleman မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health al Susan Burns - Other 6201 Dunrobbin Drive, Bethesda, Maryland 20816 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
at Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 05/03/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute & Cremation Ctr. 21. Signature of Funeral Service Licensee newfaces 1040 Rockville Pike, Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hupertension Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed <u>Diabetes</u> and burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 | Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ sign Hupothuroidism 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Prostate Cancer - In Remission 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ▼ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Medical Certification: To this After th funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

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31. Date filed (Month, Day,

10400 Cenne Kensingion

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

July araman

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 14, 2010 **Physician** a.M Messolonghites 1:30 Louisa Harden /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) **Examiner** Montgomery Renaissance Gardens Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 15, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Alabama 1 □ M 2/CXF 90 1919 Yrs. Director 434-14-3359 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wicion Examinating ust be notified at Silver Spring 1 ☐ Yes 2 No MD Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 20904 3126 Gracefield Rd. #T-226 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: à 3 ☐ Widowed 4 █ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within; of Health and Mental Hygiene. Writer and Editor Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Richard McLendin George Levy Harden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 9366 Count Kristopher Dr. Mechanicsville, VA 23116 Pages 1 and 2 C. Richard Harden (nephew) permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of July r IS 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to lor as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2XXNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease autopsy performed? 1 □ Yes 2 🗷 No Atrial Fibrillation 1 ☐Yes 2 ☐No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death. 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R121680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd. Silver Spring MD 20904 Atherine Jantae 31. Date filed (Month, Day, Year. State Registrar Denne B. Jak

DHMH 17 Rev 1/2001

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ORIGINAL

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed Be P within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral Certification: Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

attending physician

After this

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAY 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli 10810 Darnstown Rd. #202 Gaithersburg, MD 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 PM 0 Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Sounty of Death easons Randellstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ★ M 2 □ F Hours Min WASHINGTON, **Director** 579-40-0181 NOV. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No PRINCE GEORGE'S MD. CAPITOL HEIGHTS ö 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 3813 CLARK ST items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ŏ 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" 3 Widowed 4 Divorced Completed WHITE Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the PLUMBING PLUMBER 12 other Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental marked ည JOHN MOORMAN McDONALD MARY MARGARET and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MOORMAN -WIFE NORA CLARK ST., CAPITOL HEIGHTS, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 5-5-2010 4 Donation 5 Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD Signature of Funeral Service Licensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) antiont examiner? Hospital: Other: 2 KNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital 24 hours Medical 29a. Certifier 🖿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 2010 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

Georgeto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		partment of F		nd Mental Hy	giene Reg. No. 20	10 15687	
	Physici /Medic		1. Decedent's Name (First, Middle, Last		7	Jan Je:	\sim	2. Date of De Month	ath	Year Year M	
	Examin Funeral		Social Security Number 6. Security Number	Dusiya	yrs. last birthdo	Months Days		2	4c. County of	9. Birthplace (State or Foreign Country)	
	Director Manual		586-24-9526 A Usual Residence of Decedent 10b. County		. City, Town or					10d. Inside City Limits	
	r 28a-f sh	Director	VA Loudoun 10e. Street and Number	A	shburn	10f. Zip Code			10g. Citizen of W	1 □Yes 2 No	
	sath wit	Funeral D	22775 Mountville W		10 I	20148	ian ania Orial	in 2 (Specify Volume No	USA 14 Bass	- American Indian,	
980	ours after de ral', or item Exeminant	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Oivorced	12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 	In 0.5.	If Yes, specify Cuba 1 □ Yes 2 ▼ No	Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Specify:	, White, etc.	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "strain Event" or its the realined at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(G	cedent's Usual Occup ive kind of work done of b. DO NOT use retired ISE Clerk	ation during most o	of working	16b. Kind of Bus		
yland 2	should be filed wand Mental Hygie is marked other taumatic event, It	To Be C	17. Father's Name (First, Middle, Last) Ouang Nouven					s Name (First, Middle Nguyen	, Maiden Surname)	
	and 2 sho ealth and n 27 is mo		19a. Informant's Name/Relationship (Ty Anne Nguyen - Sis	,	1			or Rural Route Numb			
o,	0	15	20a. Method of Disposition 1	lemoval from State	b. Place of Dis cemetery, o	sposition (Name of rematory or other place) Cardens	re)	Date 4-30-2010	20c. Location - C	City or Town, State	
Balti	permit. Pag Department Important: I any Injury o once.	,	21. Signatur Fueral Service Licens			22. Name and Addre		Fverly Co Pike Falls		Puneral Care VA 22044	
1	Physician	6. N	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the cause on each line.	death. Do not	enter the mode of dyir	ng, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner	er	resulting in death) Sequentially list conditions, if any leading to immediate	Due to (or as a con	itaai	Enlus	B 0	Mahr	Simil	miths	
Ö,	cate be executed oblysician and the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	alica)				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
68760,	tificate b g physic as the b	edical	•	1. 1271	itall	100				merhi	
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bufal-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							e of delivery hth Day Year	
	res that signed b be deta		Part II. Other significant conditions con	atributing to death but not	resulting in the	underlying cause giv	en in Part I.		\ \ .	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	
Record	ne law requi thas been ge 2 should	Completed	Bespiratory to the state of the						an 24b. W	24b. Were autopsy findings available prior to completion of cause of	
<u>ta</u>	sician; The law certificate has birector, page 2 s	Be Co	25. Was case referred to medical examiner?					1 □ Yes of Death (Check only o	2 No 1	□Yes 2□No	
<u>o</u>	y Physic er this co eral dire		1 Yes 2 No P	lospital: 1 Inpatient 28a. Date of Injury	28b. Time	of 28c. Injur	4 LI Nurs	sing Home 5 Resi	dence 6 □ Othe		
Division of Vital Records,	r Attending er death. rector: Afte	Certification: To	1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day, Yea 28e. Place of Injury - A building, etc. (Sp	At home, farm,	M 1 🗆	k? Yes 2 ∐ No			r or Rural Route Number,	
	ospital o hours aff uneral Di			sician: To the best of my ner: On the basis of exam							
	o the H vithin 24 o the Fi	Medical	29b. Signature and title of certifier	and manner stated.	milation and/o	29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
	·->		1130				43 8			.8,2010	
e_	_ 3		30. Name and address of person who do				ore,	40 212	Driew C	1001	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 6 2010	32. Registrar's S	ignature salks	,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Lloyd 29° 2010 ear Robert Nelson 1:00P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Greenbelt Prince George's Examiner 117 Lakeside Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. OCT.12, 1935 217-32-4149 74 Washington, DC **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Directo Prince George's Greenbelt Maryland 1 Yes 2 □ No 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or alm yilury or other traumatic event, the Medical Examiner must be no 10f. Zip Code 10g. Citizen of What Country? Funeral 117 Lakeside Drive 20770 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 XMarried Yes 2 XNo þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Dewberry and Davis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lloyd Leonard Nelson Bernice Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc Jacqueline S. Nelson -wife 117 Lakeside Drive Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 5/5/2010 Silver Spring, Maryland 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Bornald Wes Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma disease or condition resulting in death) one year Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the , 981 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Pregnant at time of death ☐ Yes 2 ☐ No the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe performed? Yes 2 XNo To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X** No Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{ccccc} \text{All Residence} & 6 \sup \) Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation pleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier 1 & Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAY 05 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Granite, M.D. 115 Centerway Greenbelt, Maryland 20770

32. Registrar's Signature

29c, License number

D17572

29d. Date signed (Month, Day, Year) April 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 15689 state
Registra MEND#23a(a/b)perMD,5/6/10,BMW,Moo Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 04/30/2010 LOUISE HARTKOPF OHR 10:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9425 Overlea Drive Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, 1 □ M 2X F Country) **Director** 262-45-4081 97 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 I No MD Montgomery Poolesville 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? must be Completed by Funeral items 23a 19332 Hemostone Avenue 20837 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3℃ Widowed 4 □ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Homemaker</u> Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot မ Robert Hartkoof Matilda Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Judy Ohr - daughter 19332 Hempstone Avenue, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 Burial 2 🛭 Cremation 3 D Removal from State cemetery, crematory or other place) Ardent Cremation Svc 4 ☐ Donyetjon 5 ☐ Other (Specify) 5/3/10 Hanover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease for complic shock, or heart failure. List only on a sions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HTN 20 + years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Anorexia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Exami burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Day Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 X No 2 🗌 No 1 Tyes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗓No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at I or Attending P after death. Director: After t Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide injury 5 Pendina 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 05/03 12010 mary 129771 CVZ W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15825 Shady Grove Road, #140, Rockville, MD 20850 Mary Godwin 31. Date filed (Month, Day, Year, 32. Registrar's Signature State MAY 05

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norka Fajardo Olive May 4, 2010 11:00 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery 14111 Traville Garden Circle, Apt. 105 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Cuba Months Days Hours Min July 15, Year) 20 29 Director 267-98-9073 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20850 14411 Traville Garden Circle, Apt. 105 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: White Cuban Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury over 1 ပ Ismael Fajardo Clara Portuondo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayssa Bezos/Daughter 1201 South Ocean Dr., #2203 South, Hollywood, FL 33019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Pate 1 ★ Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 6 months Immediate Cause (Final Physician/ Inanition disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1 year Dementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-t Physician/Medical attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown b signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Completed Sacral Decubiti 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 1 ☐ Yes 2 ☐ No Yes 2 X No æ 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🖁 No Hospital Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ★ Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Phospital or Attending Pl 24 hours after death. Funeral Director: After the leted filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [] 3 [] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 05120

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

31. Date filed (Month, Day, Year, State 05

Michael Emmer, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Emmer, MD 6316 Democracy Blvd., Bethesda, MD 20817 parle 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 1, Physician/ 2010 5:45 Рм Conley Ellsworth Osgood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign Country) Michigan Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Mar 9, Day, 1925 Hours 1 🖾 M 2 🗆 F Director 381-16-5809 85 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland Director 1 Yes 2 x No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8509 Garfield Street 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. WWII Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manoe. Elementary/Seconday (0-12) College (1-4 or 5+) Claims Attorney Insurance Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Elizabeth Conley George Edmund Osgood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8509 Garfield Street, Bethesda, MD 20817 Esdeane Laurence Osgood, Spouke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Brentwood, Maryland Ft. Lincoln Crematory 5/5/10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Signature of Funeral Service Licensee M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or con resulting in death) Ph_sician/ Metastatic Lung Cancer to Brain & Liver Medical Due to (or as a consequence of Examiner Respiratory Failure Secondary to above Sequentially list conditions. Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Hypercalcemia Exami use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Possible Pneumonia Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy fo in the past 12 months? Month Day Year 5 Other (specify) been signed by the s should be detached a | Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Chronic Kidney Disease 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X**No မ 1 K Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and tit 5/2/10 1)653/2 MI) 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sundershan Siva 8600 Old Georgetown Rd. Bethesda, MD 20814 MAY 05 State 2010

Registrar

2010

Conle

Osgood,

Please Type or Print in Black Indelible Ink. Ensure All Capies Are Legible dk State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) Howard Kenneth Painter 2. Date of Death 3. Time of Death Physician/ Day 2010 Year MAY Month HOWARD PAINTER-12:10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-20-5327 1 🛣 M 2 🗆 F Months Days Hours Min March 23, **Director** 87 Maryland Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 17705 Stoneridge Drive 20878 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 XX Yes 2 □ No World Black White etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates War II 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Goliday
Nellie Pearl Goliday ည Clarence Edward Painter Nellie Coliday -Glarence-E.-Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Painter / Son 17705 Stoneridge Drive, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monocacy Cemetery May 10, 2010 Beallsville, Maryland Signature of Funeral Service Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line SEPSIS Immediate Cause (Final Onset and Death h, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DAYS NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 ☐ Yes 2XX No 3 ☐ Probably 4 CONKNOWN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? After this certificate 2 No 2 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes မ 1 Unpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending safter death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined thin 24 hours a the Funeral D Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and tit 29c. License number ٥ 29d. Date signed (Month, Day, Year) 00062623 Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAMEEN BOLANUM, MD 196 TJ DLIVE, FREDERICK, MP 2/702 30. Name and addre 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

JK 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2ď10 4:30 A Catherine Mary Petrosillo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester 55 Boston Dr. Ocean Pines 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/27/1949 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 60 MD 219-52-4210 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wed call Examiner must be notified at 1 ☐ Yes 2 No Director Ocean Pines Worcester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21811 USA 55 Boston Dr. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2: No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: white 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any injury or other trailmatter. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Galileo G. Petrosillo Mary DiLeo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Degele / friend 55 Boston Dr., Ocean Pines, MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/4/2010 Frankford, DE Cape Henlopen Crem. 4 □ Donation 5 □ 9ther (Specify) 22. Name and Address of Facility Burbage Funeral Home Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enter the sease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause we ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No ned by the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital of within 24 hours a To the Funeral D

31. Date filed (Month, Day, Year)

30. Name and address of person who

29a. Certifier

Medical

completed cause of death (Item 23a) (Type, Print)

and manner stated

legistrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Franklin Avenue, Suite 302 Berlin,

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show traust be notified at

ral", or items ?

"natural"

Health and Mental Hygiene.

Some 27 is marked other than "nature ther traumatic event, the Medical F

permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.

the

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has seen signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital c within 24 hours at To the Funeral D completely filled is

Physician/Medical

Be Completed by

Certification: To

Medical

State Registrar 29b. Signature and title of certific

Suresh

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Laurel

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

	⊸ d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobat	acco use contribute to the cause of death?
Diabetes Mel	itus PEG Tube 1 Yes	2 No 3 Probably 4 Unknown
Sacral Decubi	tus Asystole 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Failure to Thri	perform 1 □ Yes 2	ed? death?
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Imagine 1 Image: A position 1 Hospital: 1 Image: A position 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident	ce 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		et and Number or Rural Route Number, State)
29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	use(s) and manner as stated. e and place, and du <i>e</i> to the cause(s)

29d. Date signed (Month, Day, Year)

Laurel,

7300 Van Dusen Rd

20707

DHMH 17 Rev 1/2001

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Hospital

Regional

Funeral Director

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

Baltimore, Maryland 21215-0036

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

the burial-tran

or Attending Physician: The law requires that the death certificate be executed

After this certificate has been signed by the funeral director, page 2 should be detached

Box 68760,

P.0.

Division of Vital Records,

Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 04-26-2010 2:35 PM

USA

4b. City, Town, or Location of Death 4c. County of Death

District Heights

Prince George's

Race - American Indian, Black, White, etc.

Federal Government

DC

10d. Inside City Limits

17√ Yes 2 No

6319 Gateway Boulevard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1 ☐ M 2 □ TF 578-34-3106 11-29-1929 80

Usual Residence of Decedent 10c. City. Town or Location

|Maryland Prince George" District Heights

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

6319 Gateway Boulevard 20747 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 College (1-4or 5+)

Psych Technician

Completed 17. Father's Name (First, Middle, Last) Be Joseph Sulters

Mammie Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) Valerie Dawson/daughter 6319 Gateway Blvd., District Hghts, MD 20747

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State

05-03-2010 Landover, 4 ☐ Donation 5 ☐ Other (Specify) Natl Harmony PK Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee

Mary MOI Itedgman Cedar Hill FH, 4111 PA Ave., Suitland, Approximate Interval Between Onset and Death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Adenocarcinoma of Lung

disease or condition resulting in death)

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of)

Due to (or as a consequence of)

that initiated events resulting in death) Last

IF FEMALE:

23c. If yes, outcome of pregnancy 23h. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 🕅 No

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month 23e. Did tobacco use contribute to the cause of death?

05-03-2010

23d. Date of delivery

1 ☐Yes 2 ☐No

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an autopsy performed? 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

D20986

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9001 Woodyard Rd., Suite C, Clinton, MD 20906 Victor Henry,

31. Date filed (Month, Day, Year) State MAY 0 6 2010 Registrar

32. Registrar's Signature

CR 10

thours after death uneral Director:

To the Hospital within 24 hours a To the Funeral I

the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ap#îĽ 2³9 20 Î 10:17p M CHARLES L. PLUMMER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGES CHELTENHAM 10321 SARAH LANDING DRIVE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. 86 NORTH CAROLINA Director 578-36-9291 4-30-1924 Usual Residence of Decedent shov 10a. State 10b. County or 28a-f sho notified at 10c. City. Town or Location 10d. Inside City Limits rector 1 X Yes 2 No WASHINGTON DC ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral UNITED STATES 20019 4021 E. STREET S.E. ural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedon... Armed Forces? ¹ ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BLACK 3 Midowed 4 Divorced "natural" Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the WEIN SHIELD CO. ELECTRONIC TECHNICIAN 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve Ith and Mental F 27 is marked or traumatic ever မ CARROT (UNKNOWN) WILLIAM PLUMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10321 SARAH LANDING DRIVE CHELTENHAM, MD LOIS PRUNTY / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Speg MARYLAND NATIONAL 5/7/2010 LAUREL MARYLAND dure of funeral Service L 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 3005 12th NE WASHINGTON, DC 20017 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ISCHEMIC CARDIOMYOPATHY <u>YEA</u>RS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse ! 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 2 No. g 🗌 Unknown has been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4♣ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No certificate 1 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) home Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

Registrar

(Check

only one) 29b. Signature a

4041 POWDER MILL

31. Date filed (Month, Day, Year, MAY 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RD CALVERTON MD 20705

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D37142

Jeffrey Coleman

29d. Date signed (Month, Day, Year)

5/4/2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2010 MARY 3:37 P **PACKO** Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 1311 CHAPEL OAKS DRIVE CAPITOL HEIGHTS PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🕅 F Months Days Hours Min 93 KENTUCKY Director 405-09-9171 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Director 1 X Yes 2 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? with 1 Funeral 1311 CHAPEL OAKS DRIVE 20743 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 1. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after 1 Yes 2 XNo Specify: Specify: BLACK If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CHIEF OF PUBLICATIONS GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည FRED YOUNG BIRDIE FLOWERS permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORIA HUDSON/SISTER LAWRENCE AVE CHICAGO 9429 ST. IL. 60619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/18/2010 ARLINGTON CEMETERY ARLINGTON, VIRGINIA 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. der Under, ing Cause (Disease or linjury Due to (or as a consequence of): Examin • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?
1 Yes 2 No 1 Yes 2 XNo **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner's Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \begin{array}{c} \beg Hospital 1 Tes 2 **30**No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

CR 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARON PUMERANRZ M.D. 6900 GEORGIA AVENUE N.W. WASHINGTON, DC 20011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar MAY 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a-c & 10e-f, per Inf G903 5/21/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 3:40 p M May 3, 2010 Ellen Pence Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Renaissance Gardens at Riderwood Village Prince George's Silver Spring If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days Min. 1 □ M 2 □ X = Yrs. 95 Sept. 25, 1914 Michigan Director 375-14-8394 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State MD 10b. County Prince 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be men "matural", or items 23a or 28a-f show ment of Health and Mental Hygiene.
iant: if item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at - Oakland George's 1 ☐ Yes 2 No Ferndale **Michigan** Silver Spring Director 10f. Zip Code 20904 10g. Citizen of What Country? 10e. Street and Number 3160 Gracefield Road 48220 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher High School Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Hiram Elliott Alice St. Clair McFedries 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2736 Rittenhouse Street, NW, Washington, DC 20015 Daniel M. Pence/Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd. W., Silver Spi

23a. Part1. Ever the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascalar Disease years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Hypertension, Alzheimer's Dementia, Coronary Artery Disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 Jas autopsy performed? Yes 2 █ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending 5 Pending investigation the Funeral Director: After Americal Director: After Funeral Director: After Funeral Director: After Funeral Public Funeral Published Fune 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely To the I within 24 To the I x Certified Narse Practitioner 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 121680 BIID Gracefield Rd. SILVENSPITING HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Paul, Racine, SR. 2.21 PM 0) 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLTS <u>ANNE ARUNDEI</u> Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB.05,1928 9. Birthplace (State or Foreign Country) MASSACHUSETTS Funeral 12 M 2 F Months Days Hours Min. 722 03 9526 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 Yes 2 No MARYLAND ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 87 STEWART DRIVE #208 permit. Pages 1 and 2 should be filed within 72 hours after death vacapartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a may Injury or other traumatic event, the Medical Evaniner must once. Funeral 21037 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 17 Y S 2 No If Yes, Give Year or Dates: 1946-52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTANT BUILDING INDUSTRY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) OSCAR P. RACINE ပ ADELINE BLEAU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) DORIS DION RACINE (WIFE) 87 STEWART DRIVE #208 EDGEWATER, MARYLAND 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 17☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM: 05-06-2010 | CROWNSVILLE, MARYLAND 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Fundal Service Lice <u> 2973 SOLOMONS ISLAND ROAD EDGEWATER MD. 21037</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as t attending p for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Ye a 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10. Hossein, W 006 85 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or Shahr Rad Hassem 6 creen lear Drive -Shahr Bail Hassem Baltimore - MD W

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Susan Rhea ROEMER 2010 2:30 Α Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery **Examiner** 1421 Highland Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 25 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 **V**□ F 68 144-32-5712 1941 Director shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Examiner must be notified at Director Silver Spring Maryland Montgomery 1 Yes 2 No · 28a-f 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 23a or 20910 Funeral 1421 Highland Drive items ? should be filed within 72 hours after death and Mental Hygiene.
is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No Specify:} \) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Religion Cantor Be 18. Mother's Name (First, Middle, Maiden Surname)
Rose Silver 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Henry Kalb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Highland Drive, Silver Spring, MD 20910 Peter Roemer, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 05/04/2010 Lebanon Cemetery 21. Sign dure of funeral 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20012 Approximate shock, or heart failure. List only one cause on each line Interval Between nset and Death Years Immediate Cause (Final Amyotrophic Lateral Sclerosis Physiciani Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death page 2 should be detached 1 ☐ Yes ∠ ☑ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, æ 1 Yes 2 No 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number MD 31540 (DC) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 3, 2010

Registrar

DHMH 17 Rev 7/2009

100 Irving St., NW, Washington, DC

20010 #EB-3114

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Taler, M.D.,

MAY 04 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robin RUBENSTEIN <u>2</u>่ดีใก 3:30 P M Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery **Examiner** Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 26 Washington, DC Months Days Hours Min 48 213-88-0312 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location aţ Director or 28a-f sl notified 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States ō "natural", or items 23a or dical Examiner must be 20902 Funeral 1913 Wallace Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 ☐ Married ò 2 X No Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+ None the None Be filed 18. Mother's Name (First, Middle, Maiden Surname)
Karol Flink 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked of
raumatic ever ဂ George Rubenstein 19a. Informant's Name/Relationship (Type, Print) Karol Rubenstein, Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 13861 Via Nidia, Delray Beach, FL Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Judean Memorial Gardehs 05/05/2010 4 Donation 5 Other (Specify) permit. Tomohimsky delinew Funeral Home 21. Signature of Fu 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Hypovolemic Shock Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Diarrhea Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown 24b. Were autopsy findings available prior to completion of cause of Hypothyroidism 24a. Was an has autopsy certificate ha performed? Yes 2 N death? 1 🗌 Yes 2 🗆 No Downs Syndrome director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🙀 No မြ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) ပို May 3, 2010 D 68096

Registrar

DHMH 17 Rev 7/2009

State

20910

Satyam Shah, M.D., 1500 Forest Glen Road, Silver Spring, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

04 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 5, Patricia V. Richards 2010 9:08 A М Medical 4a. Facility Name (if not institution, give street and number) 7307 Riverhill Road **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Oxon Hill 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8 Date of Birth **Funeral** 1 □ M 2XXF Days Hours 585-16-7492 08/2071943 66 Director Yrs Usual Residence of Decedent shov 10a. State 10b County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f st notified 1 Yes 2XX No Maryland Prince George's Oxon Hill 10e. Street and Number ms 23a or r must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 7307 Riverhill Road 20745 USA er than "natural", or items the Medical Examiner mu 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Vinsant Mitchel 4 1 Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Richards / Son 2489 Warm Spring Way Odenton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 05/06/2010 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility 2. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Par 1. Enter the disease, or complications shock, or heart failure. List only one caus that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ NODULAR LYMPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ♣ No Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2XX_{No} Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 K Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred KK_{Natural} 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State; 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) MAY 0 6 2010

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H660665

29d, Date signed (Month, Day, Year)

20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\mathsf{Day}}{2} 0 \underline{10}$ Physician/ Month MAY **JAMES** D. ROBINSON 6:25 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY WOODSIDE CENTER SILVER SPRING Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F oCT. 4 1942 NORTH CAROLINA **Director** 237**-**64-3757 Usual Residence of Decedent or 28a-f shov 10a. State 10b. Counfy 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director DC WASHINGTON 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3700 N. CAPITOL STREET N.E. 20011 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces? 1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: WHITE "natural", 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) COMMUNICATION SPECIALIST MILITARY Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ပ MARY WILSON WILLIAM M. ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health an: CLEAR CREEK ROAD MARION, NORTH CAROLINA 28752 HOLLY NEWSOME/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 RIVERDALE CREMATORY RIVERDALE, MARYLAND Signature of Funera 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARCINOMA PANCREAS resulting in death) Medical Due to (or as a consequence of): Examiner BILATERAL DEEP VENOUS THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes Completed 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed? Yes 2 24 hours after death. Funeral Director: After this certificate 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes Other: 4 XNursing Home 5 Residence 6 Other (Specify) မ 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

within 2

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)
MAY 0 8 2010

EDWARD BELTON M.D. 1629 COLUMBIA ROAD N.W. SUITE 334 WASHINGTON, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MD 25586

29d. Date signed (Month, Day, Year)

05/05/2010

				State of Maryla				•	_	n 15704		
			For State Registrar			rtificate of L			Reg. No.	0 : 0 / 0 4		
	Physicia Medic		1. Decedent's Name (First, Middle, La Helen Car	-ol RICE	2			2. Date of Dea Month	Day	3. Time of Death		
-	Examin	er	4a. Facility Name (if not institution, giv Hospice of Queen Anr			4b. City, Town, or Centrevill	Location of Death		4c. County of Queen Ann			
	Funeral Director		5. Social Security Number 216–40–7964	8. Date of Birt June 1, Pa	^h 1 9 42	Birthplace (State or Foreign Country)						
	Maryland Ba-f show tified at		Usual Residence of Decedent 10a. State 10b. County MD Queen Anr		City, Town or Lo Stevensvi					10d. Inside City Limits 1 ☐ Yes XX No		
	s 23a or 2 nust be no	Funeral Director	10e. Street and Number 134 Bay Drive			10f. Zip Code 21666			10g. Citizen of Wh	iat Country?		
9800	e filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ☑️ No		ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White		
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed by	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done of OO NOT use retired) Cty Manageme	durina most of work	ing	16b. Kind of Busi	overnment Contract		
land 2	ould be filed wid Mental Hygi marked other matic event, f	امها	17. Father's Name (First, Middle, Last) John West					18. Mother's Name (First, Middle, Maiden Surname) Helen Esunas				
, Mary	2 shoth and the and th		19a. Informant's Name/Relationship (James M. Anselmo /So	** *	19b. Mailing Address (Street and N 134 Bay Drive, Steve			mber or Rural Route Number, City or Town, State, Zip Codensville, MD 21666				
imore	permit. Page 1 and : Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		osition (Name of matory or other plac yen Cemeters	;e) i	Date , 2010	20c. Location - C			
21. Signature of Funeral Service Licensee						22. Name and Address of FacilityFrancis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901						
P	Medical Examiner	Examiner	23a. Part 1. Anter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	one cause on each line.	requence of):	er the mode of dyin	colon,		1961 1961	Approximate Interval Between Onset and Death		
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executability 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and from the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tra	Physician/Medical I	ical	ical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pre- 1 Live Birth 2 4 Pregnant at time 9 Unknown	gnancy Fetal death 3 [☐ Ectopic pregnanc☐ Other (specify)	÷y		23d. Date Montl	,
ls, P.O.	uires that th n signed by uld be detac	by	23e, Did (obacco use continuous c						ute to the cause of death?			
Division of Vital Records,	The law require ate has been si page 2 should	Completed					24a. Was autc perf 1 — Yes					
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	□ 59 /0 4 - 4	Othe	26. Place of Death (Check only one)					
n of √	nding Physith. The After this funeral di	cate: To	27. Manny of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 28a. Date of injury (Month, Day, Year,	28b. Time o	f 28c. Injury work	4 Nursing Home 5 Residence 6 Other (Specify) ry at 28d. Describe how injury occurred					
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	l Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injuny - A		reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exan only one) 3 Certifying Nu	ysician: To the best of my kn niner: On the basis of examina rse Practioner: To the best o	ation and/or inves	stigation, in my opinic	on, death occurred a	t the time, date a	nd place, and due to	o the cause(s) and manner stated.		
	10		29b. Signature and title of certifier Much. G.	Kartina	to ani	29c. License	0152		29d. Date signed (3,2010		
			30. Name and address of person who	introwitz	CIM,	Print)	30 Maria	nst-si	ne loc	Chesterm D		
	Stat	е	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature A	3LL				5-1011		

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	For State Registrar 1. Decedent's Name	e (Firet Mid-10 1				ertifica		lealth and I Death		Reg. No	L. V 1	-	5/0		
ian/	1			,						2. Date of De Month April		^y 2010 Yea		ne of Death L5 P ^N		
ical iner		Rosemarie E. Stewart 4a. Facility Name (if not institution, give street and number)						v. Town, or	Location of Death							
IIICI		839 Woodmont Rd.						Annapo				nne Ar				
1		579–24–69	924	Sex 1 M 2 F	7. Age (In yrs. 84	last birthda Yrs	Month	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bit 0 2 / 24 /		Wa ⁰	Birthplace (St Sountry) Shingt	rthplace (State or Foreign Shington, DC		
Portor	- 1-	Jsual Residence of 10a. State Maryland	10b. County Anne A	runde1		ity, Town or							10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
Fineral Director	ם ו	10e. Street and Num		d			10f. 2	Zíp Code 21401	-		-	tizen of What ted St	-			
2	2	11. Marital Status 1 Never Marri 3 Widowed		If Yes, Give	ces? 2.4 No	.S. 1	If Yes, sp	edent of Hi ecify Cuba 2 🗓 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ar Black, Wi Specify: W		in,		
Completed	anaidii	(Spe	15. Decedent's cify only highest	grade completed)		(Gi	cedent's Usive kind of w	ork done a	ation Juring most of work	king	16b. K	ind of Busine				
		Elementary/Seco	onday (0-12)	College (1-4	1 or 5+)		lget A		st		Fed	eral G	overnm	ent		
To Re	٦ I	17. Father's Name (F	First, Middle, Las Hill	t)					18. Mother's Nan Elizabe	e (First, Middle, Maiden Surname) th Conway						
	Ī	19a. Informant's Na Melvin Po				19b. M 352	ailing Addre 20 Hor	ss (Street a	and Number or Run n Way, Da	ral Route Number	er, City or ille	Town, State, Mary	Zip Code) 1and 2	21035		
	7		Cremation 3	Removal from S	Stato	cemetery, c	sposition (N crematory or cemato	rother plac	e) 05/0	Date 01/2010		ocation - City sewater				
	ŀ	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility George P. Kalas Funeral 2973 Solomons Island Rd. Edgewater, M											eral H	lome		
ical Examiner	ŧΙ	23á. Parl 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Betwoen Support Consequence of): CHRONIC BRONCHITIS Due to (or as a consequence of): Emphysem A Due to (or as a consequence of):														
Physician/Medic	ysicially wie	F FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months? ☑ No	1 ☐ Live B 4 ☐ Pregn	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Mon								delivery Day	Year		
											23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 □ No 3 □ Probably 4 □ Unknown					
Completed by	niihiere									24a. Was auto perf 1 \sum Yes	psy ormed?	prior death	autopsy findi to completion ? Yes 2 No	of cause o		
Be		25. Was case referre	ed to medical					26. Pl	ace of Death (Che							
12	2	1 ☐ Yes 2 2		1 1	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5XXXResidence 6 Other (Specify)							ecify)				
Certificate	illeate.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be								28d. Describe how injury occurred						
		4 Homicide	determine	ed 28e. Place of building	g, etc. (Speci	fy)				28f. Location (City or To	wn, State)		vumber,		
Medical		(Check 2 only one) 3	Medical Exa	hysician: To the be miner: On the basis urse Practioner: To	of examination	on and/or in	vestigation, ge, death oc	in my opinic curred at the	on, death occurred a e time, date and pla	at the time, date	and place ne cause(e, and due to the s) and manner	ne cause(s) an as stated.			
		29b. Signature and Lan 30. Name and addre CAROL PRO		suom	D			9c. License				te signed (Mo		r)		
	- 1	20. Name and addr	ess of person wh	o completed cause	of death (Iter	m 23a) (Typ	e, Print)	# 20	toco	IATER	(Pag)	1103-	,			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Michael Gary Stone 2010 A^{M} May 9:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 Hours 181-32-6043 0873071942 Director 67 Pennsylvania Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Crofton 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2465 Vineyard Lane 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc ò 1 Never Married 2 Married ☐ Yes 2 ☐ No
Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates:1961-65 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) iould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Communication Technician Department of Defense or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Stone Lois Frew and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah A. Stone/Spouse 2465 Vineyard Lane, Crofton, MD 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory 05/04/2010 | Baltimore, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to jor as a consequence of trany leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccq use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Certificate: To 2 Other: Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De 11 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D52830 Canine Weiner (MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgak load #300 Amepsil, ND 21401 MO,900 Werner eanine

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phyllis SCHINDLER $M_{ay}^{Month}1$, $201^{9}0$ Physician/ 10:40 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Aprillonth 29 Min. Year 929 Permsylvania **Director** 81 166-24-3166 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Montgomery Rockville 1 🗆 Yes 2 💢 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Funeral United States 20852 6615 Sulky Lane within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 21215-0036 <u>۾</u> white 1 ☐ Yes 2 No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Rose Lazier Isadore Liberman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 6615 Sulky Lane, Rockville, MD 20852 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Albert I. Schindler, Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 05/03/2010 injury or Adelphi, MD Torchinisky Hebirew Funeral Home any 20012 <u> 254 Carroll St., NW, Washington, </u> that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a Part 1 Enter the disease or come Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final disease or condition Urosepsis Physicianz Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of sician and burial-transit Cause (Disease or iinjury Multiple Myeloma that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo 5 Other (specify) Month Pregnant at time of death Dav Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 05/01/10 Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? has performed? Yes 2 X Hospital or Attending Physician: The 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 1 Tes SCHNOLER, PHYLLIS 2 🗘 No 욘 1 V Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending after death. Accident Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cuto) on: To the best of my knowledge Gartifying Num only only date and place, and due to the course(s) and ingreser as state 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) May 1, 2010 30. Name and address of person who cometed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD M.D Ivan Orlando Rosa

State Registrar 31. Date filed (*Month, Day, Year*) **MAY** 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Theresa Mary Schurer May 2, Year 2010 5:25 р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 X Months Days Hours oct. Is Year 931 New dersey Director 139-24-5822 78 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3210 Norbeck Road, #301 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 0 Black, White, etc. Completed by 1 Never Married 2 Married 🗌 Yes 2 屎 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 Widowed 4 N Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked should be Frank Mertz Agnes Cowen permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Pierson Road, Morganville, NJ 07751 Michael M. Schurer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State May 3, Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee francis^{Adjess} Collvins Funeral 500 University Blvd. W., S al Home Inc. Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lactic Acidosis Medical Due to (or as a consequence of): ^eExaminer Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of); Cause (Disease or linjury the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 2**X** No 1 Yes 2X the 9 Unknown ģ signed k Id be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Small Bowel Obstruction, Morbid Obesity, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure, Urinary Tract Infection 24a, Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred XX Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, edical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month. Dav. Year) D67901

State Registrar 31. Date filed (Month, Day, Year)

MAY 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Winifred Hui-Lia Lee, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 29 Day 2010 Year 8:30 A_M Susan B. Strober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Health Services Manor Care 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral 1 M 2 X F Months Days Hours Min. Sep. Pay, Year 1937 NewYYork 073-30-6059 72 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tyes 2 No Rockville MD Montgomery Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 21 Englishman Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates er than "natural", the Medical Exar 1 ☐ Yes 2 🙀 No Specify. Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Social Worker 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ann Lapidus Nathan Hackinoff traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 East 70th Street, Apt. # 2305, New York 10021 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sl nt of Health a: If item 27 is Bruce E. Strober/Son Baltimore, or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cedar Park Cemetery | May 2, 2010 | Paramus, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Source Licensee Melissa Greenhut Mol597 22. Name and Am Zansky-Goldberg Memorial Chapels. Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Ovarian Cancer Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Failure to Thrive Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of physician and s the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 attending ph d for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2X 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Physician: The law autopsy death? 1 Yes 2 No 1 ☐ Yes 2X No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) ompleted filled in e Funeral I Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057458 inky 10 4/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6502 Kenilworth Avenue Suite 100 Riverdale, Maryland 20737 Pinky Singh, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature MAY 0 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 4:20PM HURCHIL 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washi ngton cial Security Number Hospital <u>Takoma Park</u> Adventist 8. Date of Birth (Month, Day, Year) July 24, 1928 . Age (În yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **№**M 2 🗆 F China Months Days Hours Min Director July 579**-**48-3299 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20016 US 4201 Butterworth Place NW # 409 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify. "natural" Completed 3 Widowed 4 Divorced Chinese 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marian WU Phillip Sze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Gordon Sze / Nephew Department of Health Important: If item 27 any injury or other th 23 York ST # 17B New Haven, CT 06511 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 4, 2010 Washington DC Glenwood Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Joseph Gawler's Sons Willia 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ORCAN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown signed by the a 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No ☐ Yes Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I To the Hospital or Attending Physician; 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 _ ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier ❤️Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie D006905 2010 20

Registrar
DHMH 17 Rev 7/2009

State

BERNICE

31. Date filed (Month, Day, Year)

MODD,

7600

CARROLL

AVENUE

14 Compt PARK 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 - 3	or State Registra
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Certificate of Death

neg	J. NO,		
Death			3. Time of Death
	Day	Ye ar	

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ın	Auguste Theune	Schill	ing			Month May	D. 1	ay 2	Year 010	6:15 P M		
ai er	4a. Facility Name (If not institution, give street and number)	of Death		40	c. County							
	Wilson Health Care Center	Gaitl			Montgomery							
	5. Social Security Number 6. Sex 7. Age (In yrs.	V	If Under 1 Ye Months Da		Min.	8. Date of B (Month, D March	ay, Year	904	Cour			
	577-40-7465 106 Usual Residence of Decedent)				March	23,1	904	Ger	rmany		
	10a. State 10b. County 10c. Ci	ity, Town or Lo	cation						1	0d. Inside City Limits		
tor	Maryland Montgomery (Gaither	shurg							1⊠Yes 2□No		
ire	10e. Street and Number		10f. Zip Cod)			10g. C	itizen of W	/hat Cour	ntry?		
al	407 Russell Avenue, # 503		208	7			υ	nite	d Sta	ates		
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γF	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, specify: 1 □ Yes 2 ▼ No Specify: 1 □ Yes 2 ▼ No Specify: 1 □ Yes 2 ▼ No Specify:									nte, etc.		
Be Completed by Funeral Director	3₺ Widowed 4 Divorced Year or Dates:								W	nite		
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ш	Elementary/Secondary (0-12) College (1-4or 5+)		feteria	,			1	lontge ublic	-	County		
ပို	17. Father's Name (First, Middle, Last)	l Car	LCCCIIA			(First, Middle				10012		
To B	Johann Peter Theune					Eliza	heth		Fenne	nor		
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Str	et and Numb	er or Rura							
	Bruce Eddy/Great Nephew	8801 I	Herons 1	light,	Lau	rel, M	ary1	and	20723	3		
		Place of Dispo	sition (Name of matory or other)	lace)	D	ate	20c. l	ocation -	City or To	own, State		
	1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mg1	tropoli	tan Cre	m.	5/4/2	2010	Ale:	xandr	ia,	Virginia		
	21 Superture of Funeral Service Licensee	22	2. Name and Ad	dress of Facili	ty Del	ol Fur	iera.	l Hom	ıe	-		
	Michael William							rsbur	g, M	D. 20877		
	23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death									
	Immediate Cause (Final disease or condition		Luck									
	Immediate Cause (Final disease or condition resulting in death) e. Cangestive hear typically list conditions, Sequentially list conditions, b. Cangestive hear typically list conditions,											
_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec											
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sician/Medical Examiner												
an/N	IF FEMALE: 23b. Was decedent pregnant in the pact 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fet		☐ Ectopic pregn	incv					e of delive	•		
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ρ	Part II. Other significent conditions contributing to death but not res	sulting in the u	nuenying cause	given in Fart				2 PNo		pably 4 ☐ Unknown		
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du	osierai mens					24a. Wa	opsy	24b. V	vere auto rior to co leath?	ppsy findings available impletion of cause of		
ပိ	1 Yes 2 Mo 1 Yes 2 No								2 No			
Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	TCD/Outpation	- 0 DOA	Other:	A	(Check only			(0			
i.T	27. Manner of Death 28a. Date of Injury	28b. Time of		jury at ork?		me 5 ☐ Res 28d. Describe				ry)		
atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		ork? □Yes 2□	No							
3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28. Location (Street and Number or Rural Rou City or Town, State)							al Route Number,					
Cer												
Medical Certification: To	29a. Certifier (Check only one) 1 **Certifying Physician; To the best of my kn 2 **Medicel Examiner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at th vestigation, in n	e time, date a y opinion, de	nd place, ath occurr	and due to the	e cause e, date a	(s) and mand mand place, a	nner as s and due to	stated. o the cause(s)		
ğ	29b. Signature and title of certifier		29c. Lic	ense number			29d. D	ate signed	(Month,	Day, Year)		
	14 Prheitsen chan	fuco	1 6	3411	1		m	ny	2,2	2010		
	30. Name and address of person who completed cause of death (Ite	m-23a) (Type,	Print) 20	RU	322	LL A	VER	Me	DAYY			

State

Registrar

31. Date filed (Month, Day, Year)

MAY 05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Hilda Louella Shiner April 30, Day 2010 Year 11:10 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏝 F Months Days Hours Min Nov. 14 North Dakota Director 533-22-0112 '1923l Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🏝 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 N. Leisure World Blvd., Apt. 619 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 № No Specify. If Yes, Give Year or Dates than "natural", Specify: 3 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Martin Haugsdal Bertina Stephenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)MD 20906 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Francis Shiner/Husband 3210 N. Leisure World Blvd., #619, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2X Cremation 3 🗆 Removal from State May 2010 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Alzheimer's Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page performed? Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica funeral director 26. Place of Death (Check only one) Hospital Other: 2 K No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending after death.

Director; Aft d in by the fur 1 🗌 Yes Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by 4 - Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Damien J. Doyle, MD

MAY 05

31. Date filed (Month, Day, Year)

5885788V

1801 East Jefferson Street, Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Maud Wilson Shirey 12:00 p^M May 3, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens @ Riderwood Village Silver Spring Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 126-18-8102 1 □ M 2 👿 F Months Days Hours Min Nov 12. 1921 Corintry) 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Evant for Aust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Director Prince George's Silver Spring 1 Yes XX No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, OG-3134 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 21 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No <u>ک</u> Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orion O. Wilson Louise Catherine Pressman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael C. Shirey /Son 13912 Overton Lane, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Metropolitan Crematory May 4, 2010 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Francis J. Coll:
500 University Blvd W, Silver Sprir

23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non-small cell lung cancer **Physician** 9 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-transi and Due to (or as a consequence of) physician the burial Physician/Medical death certificate use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Por Month Year signed by the a d be detached for Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? certificate has 24a. Was an Coronary artery disease 1 □Yes 2X No 1 ☐Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1X Natural r death. 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 \Buicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

State

MAY 05 Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

3110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jantac

eld Rd. Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edward Smith Charles 2010 April 10:05 A^M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number . Age (In vrs. last birthday, If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) av 9, 1935 Director 219-32-0754 74 May Tennessee Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Derwood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 17101 Briardale Road 20855 United States ıral", or items ? I Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 1954-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 - Widowed 4 Divorced Specify. 1957 Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed with thrent of Health and Mental Hygien rhant: If item 27 is marked other thant: If item 27 is marked other thany or other traumatic event, th Manager HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 0scar Smith Myrtle Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Monroe Street, Rockville, Charles E. Smith/Son Maryland 20850 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. May 4, 2010 Alexandria, Virginia Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Severe Sepsis Medical Due to (or as a consequence of) Examine Klebsiella Pneumonia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed Hypernatremia been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 😿 No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending ☐ Accident ☐ Suicide 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral Completed filled Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check one 29c. License number 29d. Date signed (Month. Dav. Year) D 67386 April 30, 2010

State Registrar 9901 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sonia John, M.D.,

MAY 05

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Chrysanthi Stevens 2010 Medical 3:05 P. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17807 Fair Lady Way Germantown Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birds (Month, Day, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min Country) Director 368-50-3189 90 July Greece Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown mit portant: If item 27 is marked other than "natural", or items be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 X Yes 2 □ No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17807 Fair Lady Way 20874 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify: Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lefteri Kanakaris Irene Kondoruci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George N. Stevens, Son 17807 Fair Lady Way, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 2010 4 Donation 5 Other (Specify) Souls Cemetery Germantown, Maryland Signature of Funeral Service Licenses ²². Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877 M01508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death WEEK Physician. RENAL FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DEHYDRATION 1 MONTH Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 23e. Did tobacco use contribute to the cause of death? ALZHEIMERS TYPE DEMENTIA Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed? Yes 2 X No certificate ! Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A ☐ Accident ☐ Suicide Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 ELLEN R.

31. Date filed (Month, Day, Year)

MAY 05

3250 STARTING GATE COURT, WOODBINE, MD 21797

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP,

32. Registrar's Signature

FARRELL,

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May, 1, 2010 Albert. Tano 12:45 a M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4303 Mahan Road Silver Spring Montgomery 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 81 Months Days Hours May 3, 1928 577-42-9323 **Director** New York Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland notified at Director MD Montgomery Silver Spring 1 ☐ Yes 2 Ϊ No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Examiner must be Funeral 23a 4303 Mahan Road 20906 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No Black. White, etc 1 Never Married 2 X Married ō Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Specify "natural", 3 Divorced 4 Divorced Year or Dates Il Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor Construction is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Angelo Pisciottano Luigia Giannella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edvige Silvia Tano /Wife 4303 Mahan Road, Silver Spring, MD 20906 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parklawn Memorial Park May 4, 2010 Rockville, MD pf Funeral Service Licens 22. Name and Address of Facility 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between months Death Immediate Cause (Final Metastatic lung cancer Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ohysician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Dav 4 ☐ Pregnanτ a

9 ☐ Unknown signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Chronic pain from lumbar spinal stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should Type II diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No this certificate has Stage 4 chronic kidney disease 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 X No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🏲 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1X Natural injury 5 Pending Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, determined 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) M Sh D51724 May 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam B. Shah MD 10810 Connecticut Ave Kensington, MD 20895

State

Registrar

31. Date filed (Month, Day, Year,

0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Malai Thotamwai 30 Year 10 4 11:37A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Days Hours Min. Country)Thailand 4 M3th P9391 218-84-9359 71 Director Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD 1 Yes 2 No Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13603 Loree Lane 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes ※※ No Black White etc. Completed by XXNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", Specify: Asian 3 Divorced 4 Divorced Year or Dates of Heatth and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Choy Thotamwai Lax Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 Franklin St. Stanford, CT 06901 Jaruwan Currie, Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other
Everly Crematory 5/9/2010 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility 1500 W. Braddock Rd. Everly-Wheatley Funeral Home Alexandria VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate becompleted filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X**XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred XX Natural 5 Pending injury Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) edical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 8 2010

Irving Mizus MVD. 10605 Concord St. Ste. 500, Kensington, MD 20895

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar 5_11_10Amend#8.PerFHPGCcr Certificate of Death No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY Day ELIZABETH M. TIMM 2010 7:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 11 6. Sex 7. Age (In vrs. last birthday) 29_ 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 □ M 2 🛛 F NEW YORK 085-44-4378 94 1915 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified a MONTGOMERY MD. ROCKVILLE 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ms 23a or must be Funeral 9701- VEIRS DRIVE 20850 USA . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mul uny or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Specify: WHITE ğ 1 Never Married 2 Married 2 X No ☐ Yes 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN SKVASIK ELIZABETH KALANIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MS. PATRICIA TIMM-DAUGHTER-13214 DUMBARTON DR., ROCKVILLE, MD. 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth GETHSEMANE CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/6/2010 ROCKLAND LAKE, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lige 22. Name and Address of Facility 2222-WISCONSIN AVE., NW Wille HYSONG CO., INC. WASHINGTON. 23a. Part 1. Enter the disease, o' complication, that c shock, or heart failure. List only one can be on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STOGE RENDL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner TENSIUN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of Examin ANE MUA burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 📈 No 25. Was case referred to medical **Division of Vital Director:** After this certific I in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending | 24 hours after death. 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.0 2010 MAY DOD 51158 Much 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 970) ULMU Dr -OCKULLE MO 20850 31. Date filed (Month, Day, Year, 32. Registrar's Sign ture State

Registrar

MAY 0 6 2010

10-03652	
Roger O.	Woods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10	571
State of Maryland / Department of Health and Mental Hygiene	

		1- For State Registrar			Certific	ate of	Death			R	eg. No.	
Physici edical Exam										ith Day Yea	3. Time of Death 0248 hrs	
		4a. Facility Name (if not institution Southern Maryland Ho		4	c. City, Town, or Location of Death Clinton				4c. County of Death Prince George's			
Funeral Director		5. Social Security Number 214–98–0066	6. Sex	7. Age (In	yrs. fast bir	rthday) Yrs.	If Under 1 Y	ear If Un		1		9. Birthplace (State or Foreign Country) Maryland
tuy		Usual Residence of Decedent 10a. State 10b. County	1_W 2_F		. City, Town		Dn .			03/21	71700	10d. Inside City Limits
yland I-f show	tor	Maryland Prince	ce George	s	Morr	nings					11	1 Yes 2 X No
h the Mar 3a or 28s	Director	4400 AlliesRoa	ad				10f. Zip Code	2074	5	1	0g. Citizen of Wh USA	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martlal Hygiene. Important: If ten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral		12. Was Dec Armed F 1 Yes orced If Yes, Give Yes	orces?		If Ye	Decedent of s, specify Cut	an, Mexica	in, Puerto R	cify Yes or No lican, etc.)	- 14. Race White Specify:	-American Indian, Black, e, etc. White
36 hin 72 hours a e. than "natura dical Examin	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	cify only highest gra College (1 year		ed) 16a.	during mo	s Usual Occu st of working I arian				16b. Kind of Bus	siness/Industry
1215-00 I be filed with ental Hygien arked other	Be	17. Father's Name (First, Middle, John Dext	Last) Cer Woo	ods					Anne	0'5	I Maiden Surriame) Sullivan	
MD 2 d 2 should th and M n 27 is m	ပ	19a. Informant's Name/Relationsh									Maryland	
MOFE, Pages 1 an ent of Hea nt: If iten		20a. Method of Disposition 1 Burial 2 XXCremation 4 Donation 5 Other Sp			cremat	tory or othe	ion (Name of a erplace) Natory	cemetery,		Date 4/2010		City or Town, State ater, Maryland
Baltil. permit. Departm Imports injury o	į,	21. Signature of Funeral Service				22. Na	lame and Address of Facility George P. Kalas Funeral Ho .60 Oxon Hill Rd. Oxon Hill, MD 20745					•
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.								est, shock, or hea	Between Onset and
)Examiner /		or condition resulting in death) Sequentially list conditions,	Due to (or as a				·					
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xecuted n and - transit		events resulting in death) Last	Due to (or as a			ME o	04 5/2	/10 1				
8760, hificate be exe ng physician as the burial -	/Medical	WUNPENDED IF FEMALE: 23b. Was decedent pregnant in the	AMENDED 23c. If yes,	outcome of	pregnancy						23d. Date of o	
Box 6876(he death certificate the attending phy-	Physician	past 12 months? 1 Yes 2 No 9 Unki	4 Pregn	ant at time		\equiv	I death 3 er (Specify)	BEctop	ic pregnanc		Month	Day Year
ires that the signed by t	ò	Part II. Other significant condition	ons contributing to	death but	not resulting	g in the un	derlying cause	given in F	art I.			oute to the cause of death? Probably 4 Unknown
cords law requ has been	Completed									24a. Was a autopoperfor	sy pr m <u>ed</u> ? de	ere autopsy findings available for to completion of cause of sath? Yes 2 No
ital Recsitions: The scertificate irector, page	å	25. Was case referred to medical examiner?	Hospital: 1	anatient 3	EP/O	utpatient		Other	(Check on		Residence 6	Other:
ing Phy After thi	on: To	1 Yes 2 No 27. Manner of Death Natural 5 Panel	28a. Date (Month,			Time of Inj	ury 28c. In	jury at Wor	k? 28	3d. Describe h	ow injury occurre	
Vision or Attendifier death Director: in by the	Certification:	2 Accident Invest 3 Suicide 6 X Could	igation rot be Fd 5	$\frac{12}{12}/10$	At home, fa		pm 1 factory, office	Yes 2K		nk Sf. Location (S	treet and Number	cor Rural Route Number, City
五 2 年 5		4 Homicide deterring 29a. Certifier 1 Certifying Physics	nined (Specify) /sician: To the bes	t of my know	hous		d at the time,	date and p	M	ornings	side, MD	
To the Hos within 24 h To the Fur completely	Medical		niner:On the basis of and manner st	of examinati			n, in my opinio		ccurred at th		and place, and du	
		Fanch Poulla	(MD					.M.E.			May 12, 201	
	-	30. Name and orders of person we Pame₁a ∟. Southall, MI				111	Penn Stre	et, Baltir	nore, MD	21201		()
St Regist	~~~	31. Date filed (Month, Day, Year)	HOISTON M	gistrar's Sig	nature	Jague 3					16.5	
HMH 17 Rev 1/20			11.		0 1	ICINIAL				OCN	//E	

DHMH 17 Rev 1/2001 OCME 2006

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, physician

Physician

Examiner

Funeral

Director

r 28a-f show notified at

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Ith and Mental Hygie 27 Is marked other t r traumatic event, th

Department of Health ar Important: If item 27 Is any Injury or other trau

MD

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Physician/Medical Examiner nse for ed by the a signed by Be Completed by page 2 s Medical Certification: To funeral 24 hours after death Funeral Director: filled in by

Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	NAICHER DIS	EASC	Onset and Deat
Sequentially list conditions, if any, leading to influentials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lus to (or ser a consequence or): C. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy or (specify)	23d. Date of de Month	elivery Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐ F	robably 4 onkr
			autopsy prior to performed? peath?	autopsy findings avai completion of cause s 2 \sum No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Sp	ecify)
27. Manne of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not to determined		actory, office 2	8f. Location (Street and Number or F City or Town, State)	Rural Route Number,
	Physician: To the best of my knowledge, death occ aminer: On the basis of examination and/or investion and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date signed (Mor	nth, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) MAY 0 5 2010

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32. Registrar's Signatu

Registrar DHMH 17 Rev 1/2001

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04-27-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Elvera Williams 3 2010 7:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forestville Health & Rehab. Ctr. Forestville Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 ☐ M 2xxF ADTIL 17 ^{Year)} 941 Country) Louisiana 434-60-5325 69 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏝 No Maryland Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? Funeral 6005 Allentown Road 20746 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ð 1 Never Married 2 X Married ☐ Yes 2 **XX**No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if fiem 27 is marked other than any injury or other traumasis. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Keypunch Operator Academy of Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Raymond Washington Sr. Rachel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6005 Allentown Road Suitland, Maryland Claude Williams / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 6/8/2010 Arlington Nat. Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature d Funeral Service Lipe 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final 4 Tard Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
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5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ĀNo
9 ☐ Unknown Month Year signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4xx Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXXIatural 5 Pending work' 1 ☐ Yes 2 ☐ No

10

State Registrar

Medical

KichARD PALMER 31. Date filed (Month, Day, Year) MAY 0 8 2010

Accident Suicide

☐ Homicide

29b. Signature and title

29a. Certifier

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mn

Southern are SE Suite 310 1328 32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Stripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0055120

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Washing ky

29d. Date signed (Month, Day, Year)

05/05/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 4, 2010 Woods 11:58 A M Anne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4400 Allies Road Morningside Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Treland 1 □ M 2 🐺 F Months Hours Min. (Month, Day, Year) Feb. 12, 164-36-8328 71 Director ,"1939 Usual Residence of Decedent f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Prince George's 1 Yes 2 XX No Morningside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4400 Allies Road 20746 USA and Ireland 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2xx No Specify: White XX Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Home 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ O'Sullivan UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Woods / Son 1420 Wrighton Road Lothian, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it cemetery, crematory or other place)
Nat'1. Memorial Park 1 X Burial 2 Cremation 3 Removal from State 05/10/2010 Falls Church, Virginia any injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati f Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home P.A. ala 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death ₹nysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical with Liver metasti Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ■ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown sate has been signed by page 2 should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by aneurysm Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No ■ Natural 5 Pending within 24 hours after death.

To the Funeral Director, A completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20T0 30° 07:45 BESSIE E. WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min (Month, Day, Yea Virginia Director 578-50-6852 95 July Usual Residence of Decedent f show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified , or items 23a or 28a-1 1 Yes 2 X No MD Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8121 Neville Place 20744 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural" Specify: Completed Year or Dates **Black** event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Page Aurelia Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. 8121 Neville Place, Ft. Washington, MD Linda E. Jackson, Goddaughter 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat.Mem.Park May 7, 2010 Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 8914 Quarry Road Ames Funeral Home, Manassas, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause yne of line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or ilnjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for a 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YPER-TENSION 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? STEOMETHATIS 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 **N**o Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 \sum Yes 2 \sum No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Name and address of p

31. Date filed (Month, Day, Year)

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04/29/2010 REGINALD K. YIRENKYI 1047 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville Social Security Number . Sex 1 ፟፟፟X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, 03/13/ Country) Director 577**-**66-8572 67 West Africa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1X Yes 2 □ No MD Rockville Montgomerv 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral 126 Johnson Drive 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Black "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government is marked other aumatic event, th Biochemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas S. Yirenkyi Comfort Amobea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnson Drive, Rockville, MD 20850 27 Margaret K. Yirenkyi - wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from 05/29/10 Gatenof 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Heaven Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home Leval 246 N. Washington St, Rockville, MD 20850 fions that caused the death. D. Fot enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 12 days 23a. Part 1. Enter the disea 4, or complice shock, or heart failure. List only on Immediate Cause (Final Physician/ Stroke - Cerebrovascular accident disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Uncontrolled hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or imjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🛚 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signatu

and title of certifier

05

Mendhiratta 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

2401 Research Blvd,

32. Registrar's Signature

29c. License numbe D38262

#330, Rockville, MD 20850

04/29/2010

Homer Thomas Anders

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are	Legib
	State of Maryland / Department of He	ealth and Mental Hygiene	

ase Type or Print in Black Indelible Ink. Ensur			
State of Maryland / Department of Health an	d Mental Hygiene	2010	15725
Certificate of Death	Reg. No.	.010	13/23
(First, Middle Last)	2 Date of Death	· · · · · · · · · · · · · · · · · · ·	7. Time of Death

		1- For State Certificate of De	eath	, 0	2011 a. No.	1 15/2			
Physic Medical Exam		Decedent's Name (First, Middle,Last) The Company of the Comp		2. Date of Death Month		3. Time of Death			
nedical Exam	11161	Homer Thomas Anders, Jr. 4a. Facility Name (if not institution, give street and number) 14b. C	ity, Town, or Location of Deat	May 17, 20	10 4c. County of Death	1810 hrs			
			atonsville	11	Baltimore Cou				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or			
Director		220-56-7642 1\(\overline{X}\)M 2\(\overline{F}\) 60 Yrs.	onths Days Hours Mir	FEB 26		_{untry)} Carolina			
Š.		Usual Residence of Decedent 10a State 10b County 10c City Town or Location			9 = 3 = 1				
ow any		MD D T				10d. Inside City Limits 1 Yes 2 No			
Maryland 28a-f show	ctor	- Jazzaniozo	Catonsville	140	g. Citizen of What Cour				
he Ma or 28 ified a	Director	232 N. Beaumont Avenue		10		ury?			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygelva and Part or items 23a or 28a-f sho arrived other than "natural", or items 23a or 28a-f sho mastic event, the Medical Examiner, must be notified at once.	<u> </u>		21228 cedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Ameri	can Indian, Black,			
death or iten nust l	nuei		pecify Cuban, Mexican, Puerto		White, etc.				
after ral", c	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		Specify: W	hite			
hour hatu		during most of	sual Occupation (Give kind of f working life. DO NOT use ref		16b. Kind of Business/I	ndustry			
D36 thin 72 re. than edical	Jple								
5-0036 led within 7 Hygiene. tother than	Completed	2 Maintena 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	Hotel aiden Surname)	·			
21215-0C ald be filed wit Mental Hygien marked other c event, the M	Be	Homer Thomas Anders	Beulah	Ir	ene Ya	ates			
MD 2121 12 should be f th and Mental 127 is marked umatic event,	ဥ	Fr	ress (Street and Number or			Zip Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygene. Important: If item 27 is marked other than "mai nijury or other traumatic event, the Medical Exa		Karen Lynn Anders, wife 232 N. B 20a. Method of Disposition 20b. Place of Disposition	Seaumont Ave.	Catonsy	ille, MD 2	21228 Town State			
Baltimore, Normit. Pages I and Department of Healt important: If item		1 Burial 2 X Cremation 3 Removal from State crematory or other pl	ace)		·				
Baltim permit. Pag Department Important: injury or of		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee George MacNab 22. Name	tory, Inc. 05/	<u>/19/10 </u>	Baltimor	e, MD			
E De		sleve EMa He 299	Frederick Ro	emation a	Society of	MD, Inc. 21228			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the morfallure. List only one cause on each line.	de of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval			
/Medical Examiner		Immediate Cause (Final disease a. Hanging				Between Onset and Death			
,		or condition resulting in death) Due to (or as a consequence of):							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.							
cuted ind transit		events resulting in death) Last Due to (or as a consequence of): d.							
al -	Medical	UNPENDED AMENDED							
760, Icate be physic the bun	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	-			
ox 687 eath certific attending for use as th	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal decedent pregnant at time of death 5 Others (1)		ancy	Month D	ay Year			
Box e death c the atten the atten ed for us	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (S	Specify)		ì				
cords, P.O. Box 68' law requires that the death certification has been signed by the attending should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tob	acco use contribute to t	the cause of death?			
S, P	d by			1 Yes	2 ✓ No 3 Prob	ably 4 Unknown			
cords, P law requires t has been sign	Completed			24a. Was ar autopsy		opsy findings available ompletion of cause of			
Record The la	EO			perform 1 V Yes 2					
of Vital Records, ing Physician: The law require After this certificate has been siminal director, page 2 should the control of the control o	Be	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)					
f Vid	P	1 V Yes 2 No Inospital 1 Inpatient 2 ER/Outpatient 3			esidence 6 🗸 Other	Scene			
드형글근데	.: 	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: FOUND: FOUND:	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe ho Subject hang	w injury occurred ed self				
Division tal or Attendin rs after death.	icati	2 Accident Investigation May 17, 2010 1810 hrs		29f Logation (Ctr	and and Number of Div	nel Doute Number Office			
Div	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Suicide 6 Could not be determined (Specify) Woods 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) S. Rolling Road and 195, Catonsville, MD							
Divisio To the Hospital or Attenwithin 24 hours after deat To the Funeral Director	<u>a</u>								
o the omple	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
F 3 F 5	ž	not of a latter of the	29c. License number		29d. Date signed (Mon	th, Day, Year)			
		dull home	O.C.M.E.		May 18, 2010				
5V		30. Name and boddess of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Pen	n Stroot Daltiman	D 24204					
	ate	Russell Alexander MD. Assistant Medical Examiner 111 Pen 31. Date filed (Montb, Day, Year) 32. Register's Signature	n Street, Baltimore, M	D 21201					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year A M 2010 Medical Facility Name (if not institution, give street HTT) ASH/NG to A Examiner County of Death 8. Date of Birth (Month, Day, Year) July 6, 1927 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🟋 F Director 220-22-1692 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland | Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 613 Laurel Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Completed by 1 Yes 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Porter Supply N/A Receptionist Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Freiman Anna Walters Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 613 Laurel Drive Pasadena, Maryland 21122 Homer R. Ash (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/21/10 Baltimore, Maryland Loudon Park Cemetery: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15785 Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner UWSONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to force a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attendion abusing and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie, 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURHAVE MIDICAL

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

Robert Paul Barenes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2010 15727 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Da May 7, 2010 **Medical Examiner** 1145 hrs Robert Paul Barnes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country Months Hours Director 1X M 59 2 F Dec 29. 1950 Maryland Usual Residence of Decedent ıny 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 28a-f shov 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 514 Rappolla Street 21224 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 4 Divorced 3 Widowed Yes, Give Year or Dates: 1 Yes 2 No specify: White Specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Cook Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Barnes Elizabeth Hassett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Barnes, Brother <u>514 Rappolla Street Baltimore,</u> Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 05/19/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensey Thomas Gregor Signature of Funeral Service Licenses Thomas Gregor

22 Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryl
Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland Physician failure. List only one cause on each line Between Onset and /Medi I Death a. Mulitple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. cal UNPENDED After this certificate has been signed by the attending physician timeral director, page 2 should be detached for use as the burial -AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month Day Year) May 7, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 0605 hrs Pedestrian struck by auto neral Director: filled in by the f 5 Pending 1 Yes 2 V No 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Baltimore Avenue at Cherry Hill Road, College Park, MD determined 4 Homicide (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

Russell Alexander MD

29b. Signature and title of certifier

Assistant Medical Examiner 32. Registrar's Signature

and manner stated.

39. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DOME

29d. Date signed (Month, Day, Year)

May 8, 2010

ORIGINAL

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Max Blumberg Physician/ Month Day Year : 45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice @ Northwest Hospital Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month Day, Year) Days 1 X M 2 🗆 Hours Baltimore Director 61 217-50-7080 Dec Usual Residence of Decedent fshow 10a. State 72 hours after death with the Maryland 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9847 Bale Court United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced er than "nature , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Finance Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Shirley Melvin Blumberg unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Blumberg/ Wife 9847 Bale Court, Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/20/2010 Baltimore, Maryland . Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facili@remation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ End-Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 2 No 1 Yes 2 9 Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 No s after deam.

ral Director: After this ceru...

'in by the funeral director, pe 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 4 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending ☐ Accident 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier 🚅 🌜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0057465 5/20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Av., 5-235, Baltimore, MD. 21209. Sharlene Rajapakse, Mip

Registrar

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willie Edward Boyd Month 8:37P 14 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4807 Kimberleigh Road Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F (Month, Day, Year) 88 **Director** 216-18-4692 ept. Ő. 1921 Carolina Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/AMarylan¢ Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4807 Kimberleigh Road 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Year or Dates. WW2 1 ☐ Yes 2 😾 No Specify: SpecifyBlack "natural" Completed 3 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) atapsco&Back River Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eunice Shelton Charles Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kimberleigh Rd Baltimore, MD 21212</u> Jeanette Boyd /wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills,MD .Cem. 4 Donation 5 Other (Specify) 21. Signature of a neral Savice Lice 22. Name and Address of Facility Chatman-Harris Funeral Home darra 5240 Reisterstown Rd Baltimore, MD Part 1. Enter the alsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final neart FAILUre Confestive Ph_sician/ isease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam The law requires that the death certificate be executed 1ABETES attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 → No ours after death.

eral Director: After this certification in by the funeral director, I the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours Funeral Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completed fil Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5102 2016 Maill 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street DOIT 5901 North CUN M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Bertha M. Brown May 19 8:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ridgeway Manor Nursing Home Baltimore Catonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. 3/18/1917 Country)
Maryland 212-03-7054 Director 93 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2111 Smith Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker 8 Box Factory n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ George O'Neal Anna Hlafka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Brown / Son 1925 Halethorpe Avenue, Halethorpe, Maryland21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Meadowridge Mem. Pk. : 5/24/2010 Elkridge, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 2). Signatur of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death umonic disease or condition resulting in death) Examiner Completed by Physician/Medical

Physician/ Medical Examiner

any

permit, Page 1 a Department of H Important: If ite

mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthrent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show fortant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

<u>. </u>	Sequentially list conditions,	h. ————————————————————————————————————								
Examiner	if any, reading to immediate cause. Enter Underlying	pue to (or as a consequence of).	15							
can	Cause (Disease or linjury that initiated events	O								
Completed by Physician/Medical		■ d								
Me	IF FEMALE:									
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery							
sici	1 🗆 Yes 2 🔀 No	4 Pregnant at time of death 5 Other (specify)	Month Day Year							
hy	9 Unknown									
γF	Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death?								
q p	Uniham Tract 91	contributing to death but not resulting in the underlying cause given in Part I. Jecton, Bladder concumon, nias, Hypothysoidism, Hypothension, Osteoposusis	1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown							
ete	Adam	h Maria	/							
ldu	HISTAL COSTANTA	nias, hypothysolaism, hypertension,	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of							
S	Osteoartmitis.	às rea posusis	performed? death? 1 ☐ Yes 2 🐼 No 1 ☐ Yes 2 ☐ No							
Be	25. Was case referred to medical examiner?	20. Flace of Death Check to	nly one)							
2										
	27. Manner of Death 1 Natural 5 □ Pending		d. Describe how injury occurred							
Certificate:	2 Accident Investigat	on M 1 Yes 2 No								
ĬĮ.	3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number,							
		building, etc. (Specify)	City or Town, State)							
dical		nysician: To the best of my knowledge, death occured at the time, date and place, and								
2	(Check 2 L Medical Exa	miner: On the basis of examination and/or investigation, in my opinion, death occurred at th	le time, date and place, and due to the cause(s) and manner stated.							

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12754

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

within 24 hou

To the Fune

completed file

29b. Signature and title of certifier

31. Date filed (Month

Lettra Kaja WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJA MD

32. Reg

4367 Hollins

John May	
sion of Vital Records, P.O. Box 68760	
P.O. I	
Records,	-
f Vital	
sion of	Attach alling

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death DOROTHY LOUISE BACHMAN Physician/ Month 15^{Day} 2010 2:53P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 309 Willow Avenue Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F 87 Sept. 22-1922 217-12-0308 Marviand **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore County Baltimore Maryland 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 309 Willow Avenue within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🙀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3√XWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home 12 yrs. Housewife yr. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Harold Ferguson Clara M. Spicer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Bachman (Son) 607 Sherry Drive Eldersburg, Md. 21784 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State XM Burial 2 Cremation 3 Removal from State 9 Gardens of Faith 5~19~2010 Baltimore, Maryland injury 4 Donation 5 Other (Specify) guatare of Funeral Service Ocenses ²LassanAddFបิที่อีซิสั่ว Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disea Part 1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line. death. Do not enter the mode of dving. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury atheres clerote candiova attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown **Director:** After this certificate has been signed by the a in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bloom anessone 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 199 performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Certifical 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3002769 e of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, per yerba1 G903 5/20/10 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ F. Month Ray Byrd 7:30 2010 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2464 Terra Firma Baltimore na Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 X M 2 D F Months Days Hours Min (Month Day, Year) 2-24-1924 251-22-7740 86 Director S.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MID Baltimore 1 X Yes 2 No na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2464 Terra Firma Road 21225 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Coca-Cola Elementary/Seconday (0-12) College (1-4 or 5+) Bottling Co. 3rd grade Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Buster Barksdale Elma Boston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Williams-Nephew 1630 Sherwood Avenue Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Pk 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-12-2010 Randallstown, MD 21. Signature Pun Al Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 Physician disease or condition resulting in death) DYTATE 1475 Medical Due to (or as a consequence of) Examiner rostatic Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying Examine Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate archoria 2 🗆 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: tome 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No injury s after death. 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D25373 MAY 06,2010 me and address of person who completed cause of death (Item 23a) (Type, Print) ERRY 31. Date filed (Month, Day, Year, arke Registrar's Signa State Registrar

Amend #18 per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 1 9 Blanche E. Bell 2010 12:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 0ct. 12 1909 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🖵 F Months Country) Director 212-32-1716 100 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f MD 1 ☐ Yes 2x No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23aFuneral 615 Chestnut Avenue 21204 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. 9 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2x No Specify: white "natural", Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) n/a Governess Home Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles H. Bell Annie Burnham Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nancy Kinnear/niece 2 Junco Ct., Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 4 Dongtion 5 Other (Specify) Baptist Ch. Ceh. 5/24/10 22. Name and Address of Facility
emmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Bryan 23a. Part 1. Enter the disease, or complication shock, or want failure. List only one call caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or beart failu Immediate Couse (Final disease or comition resulting in death) Onset and Death Physician/ 7 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 Le 9 Unknown as been signed by the 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PLAGIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an **Director:** After this certificate has I in by the funeral director, page 2.9 performed? Yes 2 No 2 🗆 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🗖 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after determined building, etc. (Specify) e Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Numer Praction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of ce 29c. License number MAY 19, 2010 30. Name and address of person who completed cause of death then 23a) (Type, Print) 6565 N. Charles St. Suite 203, Towson, MD M.D. 31. Date filed (Month, Day, Year N. Anthony Riley, Regist Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Marviano Pepartment of Realth and Mental Hygiene

		•	Tol	ertificate of Death_	Reg. No. 2 0 1 0 1 5 7 2 1.						
	Physicia Medic		Decedent's Name (First, Middle, Last) Lawrence E. Blackwell		Date of Death Month Pay Pay Pay Pay Pay Pay Pay Pay Pay Pay						
	Examin		4a. Facility Name (if not institution, give street and number) 7011 Sheriff Road	4b. City, Town, or Location of Death Landover	4c. County of Death Prince George's						
Ī	Funeral Director		5. Social Security Number 5.77-26-7975 6. Sex 1 M 2 □ F 86 Yrs	y) If Under 1 Year If Under 24 Hrs. 8	Date of Birth 9. Birthplace (State or Foreign Was Will Waton, D.C.						
	ind thow at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits						
	Maryla 28a-f s otified	irect	Maryland Prince George's Lan	ndover	1X☐ Yes 2 ☐ No						
	h with the	Funeral Director	10e. Street and Number 7011 Sheriff Road	10f. Zip Code 20785	10g. Citizen of What Country? U • S • A •						
9003	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☆ Yes 2 ☐ No 1943— If Yes, Give Year or Dates. 1946	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric Yes 2x No Specify: 	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black						
21215-0036	vithin 72 hou jene. In than "nat the Medica	Completed by	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working DO NOT use retired) fficer	D.C. Government						
Maryland 2	d be filed v Mental Hyg arked othe itic event,	To Be	17. Father's Name (First, Middle, Last) Edward Blackwell		irst, Middle, Maiden Surname) avassa Blackwell						
, Mary	nd 2 should salth and N n 27 is ma er trauma			ailing Address (Street and Number or Rural R $3rac{1}{2}$ $A1abama$ $Avenue,$ 3	oute Number, City or Town, State, Zip Code) S.E. Washington, D.C. 20019						
Baltimore,	o + + 5		1 ➡ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington	sposition (Name of Figure 1) 5-21 Titor of Crematory 5-21 The Nature Company 6/2	2010 A rlington, Virginia						
Balt	permit. Pag Department Important: any injury once.		21. Signature of Fundal Service Licensee / 10 aloo 977	22. Name and Address of Facility Mars 4217 9th Street, N.W.	shall's Funeral Home, Inc.						
	Inysician/ Medical		23a. Patril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of):								
	Examiner	L	Due to (or as a consequence of): Sequentially list conditions, b.								
~	uted nd ransit	Examiner	if a y, leading to him ediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.								
° 8	ificate be executed g physician and as the burial-transit	Medical E	resulting in death) Last Due to (or as a consequence of): d.								
			IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery						
Box	that the death certif ned by the attending detached for use a	Physician/	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year						
ls, P.O.	requires that to been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown						
of Vital Records,	law has e 2	Completed			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No						
'ital	sician; The certificate irector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital: Inputient 2 FB/Outpa	26. Place of Death (Check or							
n of V	Attending Physician: # death. ector: After this certific by the funeral director,	cate: To	27. Manner of Death 1	of 28c. Injury at 28c	5 ☐ Hesidence 6 ☐ Other (Specify) I. Describe how injury occurred						
Division	al or Attences after death	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28i	. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician; within 24 hours after death in 24 hours after death for the Funeral Director. After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s) and manner stated.						
	To the I within 2 To the I complex		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) Hospital Dri.	ve Chowards Hamfand						
Ī	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature A Y 2 0 2010 Aurus S. Mark	,							

		Please	Type or Prin							_	le.	
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 7 7								15705			
	7.	1. Decedent's Name (First, Middle, Last) 2. Date of Death							4. U.	U	3. Time of Death	
Physicia /Medic	_	Katherine	e E. Brov	wn				Month 5	18	-1 c	Year	10:15 AM
Examin		4a. Facility Name (If not institution, give Manor-Care Dula			4b. Cit	ty, Town, o Tows	r Location of Deat	h		alti		е
Funeral Director		210 20 0000	ex 7. Age	e (In yrs. last birt	Yrs. If Unc	der 1 Year is Days	If Under 24 Hrs Hours Min.	8. Date of Bi	^{rth} 3 ^y , 19			place (State or Foreign try)
land ow it		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
e Mary a-f sh	ctor	MD Balt	imore		To	wson	1					1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 20 Lambouren	Rd. Uni	t 307	10f. 2	Zip Code 212	04		10g. Ci	tizen of W	nat Coun	try?
after dea or items niner mu	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 Yes 2				dispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	Black	, White,	
ours aural", c	Be Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			2 No	Specify:		10)	Specify:		
in 72 h n "nati	plete	15. Decedent's Ed (Specify only highest gra			Decedent's U: (Give kind of life. DO NOT	sual Occup work done use retire	oation during most of wo d)	rking	16b. K	(ind of Bus	iness/Ind	dustry
ad with /giene. er tha	lmo _C	Elementary/Secondary (0-12) 8th	College (1-4or 5		ırse's	Aid						itan Hosp
I be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Solomon					18. Mother's Na Annie		e, Maider	n Surname)	
should and Me s mark umatic	LO L	19a. Informant's Name/Relationship (Type. Print)				and Number or R	ural Route Numi				
and 2 ealth a m 27 is		Isabelle Faulce	on (daugl									id.21204
ages 1 int of H t: If ite / or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	- y	Disposition (A		Tia v	24,20]	0	ocation - C		
mit. P bartme sortan / injun		4 Donation 5 ☐ Other (Specification 2) Signature of Funeral Service Licer		CAPLE	22. Name		st Cem. S. Scrug	rae Fur	Su	rry	Co.	VA
and Dee		Ollmadine	7/Acr	unch	1412	E.	Prestor	n St. I	3alt	o, Mo	. 2	
		23a. Part1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lir	the A. Don								Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. <u>NYOY</u> Due to (or as	a consequence of			Rumon		See	vze		
Examiner		Sequentially list conditions.	b. Type	20	jabete	25 /	Mellit	US				
nted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dure to (or as	(or as a consequence or):								
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cate be physici the bu	dical		-d									
ath certifi tending or use as	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy 2 ☐ Fetal death	3∐Ectopio	pregnanc	у			23d. Date Mon		ery Day Year
at the dez by the at tached fo	Physician/Medica	1 Yes 2 No 9 Unknown	4□Pregnant at 9□Unknown	time of death	5 Other	(specify) _				IWIOII		
quires tha	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlying	g cause giv	ven in Part I.					he cause of death?
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an: Tl tificate tor, pa	Be Co	25. Was case referred to medical					26. Place of De	1 X Yes ath (Check only		0 1	□Yes	2 □ No
hysici this ce	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		tpatient 3□		4 X Nursing i	Home 5□Res	idence	6 □Othe	r (Specif	5/)
ding P h. After (funera	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Day	ry 28b. T y Year) Ir	ime of njury M	28c. Inju Wor 1 🗀	ryat rk? Yes 2∐No	28d. Describe	how inju	ury occurre	d	
or Atten after deat Directors in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, fai c. (Specify)	rm, street, fact	tory, office		28f. Location City or To			r or Rura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Co		ysician: To the best on the basis of and manner sta	f examination an								
To the within To the comple	Med	29b. Signature and title of certifier	-lin	60		29c. Licens	544) 4	5	_ 10)	Day, Year)
31		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)	1100	Brookly	410 121	<u> </u>) /> ~	> / A	
Sta	te	Grus Asadi, 6 31. Date filed (Month, Day, Year)	32. Pegistra	monds ar's Signature	lane #	-1-5	10011	(VI) [VI]) 0	160	- 7	
Registr		MAY 20 20	110 Senew	n B.	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18, 1:45a M John Kinzel Bain May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Dec • 17 9. Birthplace (State or Foreign Country)
Tennessee **Funeral** 1 🛛 M 2 🗆 F Hours Min 69 Yrs. Director 414-60-4177 1940 Usual Residence of Decedent 28a-f shov 10b. County 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Aberdeen ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 335 Graceford Dr 21001 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No 1960—
If Yes, Give
Year or Dates. 1981 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Military U.S. Government 12 4 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John D. Bain Lucy Carnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. Betty M. Bain (wife) <u>335 Graceford Dr., Aberdeen, </u> MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 5/21/10 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that consect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ myucardial disease or condition resulting in death) mmediate Medical Examiner (Orunary artern Lenears Sequentially list conditions. Examiner rany, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): years attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical NONTASULO Oppendant Diahetes years Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year ned by the a e detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? þ Hypothyruidism 1 Ses 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at eral Director: After filled in by the funer (Month, Day, Year) Natural 5 Pending 2 Accident
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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number

000048050 29d. Date signed (Manth, Day, Year) 5/10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parke St. #400 Aberdeen mD 2100/ mo 15 rashant hukla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ :15AM Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Chesapeake Hospice House Linthicum Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 M Min. Hours (Month, Day, Year) Months 81 Director 227-36-6163 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be an exercised. 10d. Inside City Limits 10a. State 10c. City. Town or Location **Funeral Director** 1 Yes 2 X No Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1239 Reese Road 21144 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2**X** No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 x Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Silk Screen Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rudell Carroll Dora Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Sherrock Daughter 5222 Lightfoot Path Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk 5-17-2010 Elkridge, Maryland Signature of Funeral Service Lis Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 M01176 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part k, or heart failure. List only one cause on each line te Cause (Final Messels Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a gornsequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 No After this certificate 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) TATE Other: 1 ☐ Yes 2 X No မြ 4 Nursing Home 5 Residence 6 Wother (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar strar's Signature

10-03642 Roy Charles Cla	rk	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		egible.	0 1573
Physicia	n/	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of D	Reg. No.	3. Time of Death
Medical Exami		Roy Charles Clark	Month May 11,		1400 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	
.1		434 East Main Street Hancock	_	Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min			Birthplace (State or Foreig Country)
		298-36-2237 1\(\frac{1}{M}\)M 2 F 66 Yrs. 1003 100	Apri	124,1944	Ohio
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and F show	ō	Florida Hillsborough Ruskin			1 Yes 2 No
Maryl	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Ē	1209 River Drive, Suite 29 33570		U.S.A.	
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of Hispanic Origin?)		No- 14. Race - An White, etc	nerican Indian, Black, c.
her de		3 Widowed 4 Divorced of Yes, Give Year 965-1968 1 Yes 2 No specify:		Specify: W	hite
ours at atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Busine	
o 72 h	lete	Elementary/Secondary (0-12) College (1-4 or 5+) 12 during most of working life. DO NOT use reti	red)		
OO3	Completed	Truck Briver	(Circt Middle	Automot	ive
215. tal Hy ked of the of the	Be C	Roy W. Clark Elizab			
213 ould b d Men s mari	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route No	umber, City or Town, St	
MD d 2 sh lith and 17 is		Wendy Marie Shanesy 539Brainard Drive,			
ore, of Hea of Hea If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	•
Limc Page ment tant:		4 Donation 5 Other Specify: MiamiValleyCrematory	5-20-	10 Dayton	,Ohio
Ball permit Depar Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ma	rzull	o Funeral	Chapel, P.
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	d , Bal respiratory a	timore, Ma mest, shock, or heart	ryland2124 Approximate Interval
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscleortic cardiovascular disea	se		Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			1
	<u>,</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	xamine	cause. Enter Underlying Cause (Disease or injury that initiated C.			X .
msit ge 'd' '		events resulting in death) Last Due to (or as a consequence of): d.			
executed ian and ial - transit	<u>ica</u>				
60, ate be shysici	Med	X UNPENDED AMENDED 23a,PII,27,per ME g905 7/29/10 TT IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	erv
687 certific ding p	jan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Out of Secretary	псу	Month	Day Year
Box 68760 e death certificate b the attending physi	Physician/Medical E	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and fumeral director, page 2 should be detached for use as the burial - transmission of the state of the sta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
S, P	ed by	Chronic obstructive pulmonary disease	1Ye	es 2 No 3 P	robably 4 Unknown
ord: w requ	Bet		24a. Was	ppsy prior t	autopsy findings available completion of cause of
Rec The la cate h	Completed		1 ✓ Yes	ormed? death	
of Vital Records, ng Physician: The law require After this certificate has been sinneral director, page 2 should be	B B	25. Was case referred to medical examiner? Hospital: 1 Inpution 2 EP/Outpution 3 DOA Other, Number 2 DOA Oth			
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on on on on on on on on on on on one function of the one function on one one one one one one one one on	흲	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	zou. Describe	s now injury occurred	
Division tal or Attendir rs after death. al Director: A	<u>ë</u>	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc.	28f. Location	(Street and Number or	Rural Route Number, City
Div pital o	Certification:	Suicide 6 Could not be determined (Specify)	or Town,	State)	
e Hosp 24 ho e Fun etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	the time, date		
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (A. May 12, 2010	fonth, Day, Year)
2 2	-	30. Name and address of person who completed gause of death (Item 23a)		Way 12, 2010	
oxoend		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	7	31. Date filed (Month, Day Year).			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Day 2010 ear Juanita F. Coleman 14. 1:58 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 417 Kennard Avenue Harford Edgewood 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/14/48 1 M 2 M F Days Hours Min. **Director** Yrs Mary Land 218-54-0899 61 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Harford Edgewood 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be with Funeral 417 Kennard Avenue 21040 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 Mo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) 4 CPA Price Waterhouse Cooper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ၉ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic Ellwood Stolins Delma Sites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 J Piccadilly Loop Yorktown, VA. 23692 Mr. Christopher Hallameyer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 □ Donation 5 🗷 Other (Specific ombment Loudon Park Cemetery 5/18/10 |Baltimore, Maryland 21. Signature of Euneral Service Lice 22. Name and Address of Facility LOudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or conshock, or heart failure. List only hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metaszan disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or linjury Due to (or as a nonsequence of Exami the attending physician and thed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year 2 No g Unknown g Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed al or.
rs after dearn.
ral Director: After this cerum.
"In by the funeral director, pe Yes 2 Alo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 **X**No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural N 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign 29c. License number

13

State Registrar AARON

70

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2010

TOUSEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b per doc g904 6-14-10 yt
amend item 23b per doc g904 6-18-10 yt
6-18-10 yt
Certificate of Death

Reg. No. 20 For **a** State Registra 1-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MICH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday. **Funeral** 1 XM 2 F Months Days Hours Min Yrs 10-13-1960 maryland 49 Director 216-88-0341 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show aţ 1 Yes 2 XX Funeral Director LAKE RIDGE VIRGINIA PRINCE WILLIAM 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö must be items 23a USA 12261 GRANADA WAY 22192 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Examiner 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify Specify ≥ WHITE 3 Widowed 4 Divorced 1960 Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than COUNTY GOVERNMENT FIRE FIGHTER the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be BETTY MOUZON ROBERT J. DUNN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12261 GRANADA WAY, LAKE RIDGE VIRGINIA 22192 PATRICIA PEDIGO-DUNN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State WOODBRIDGE, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 5-14-2010 POTOMAC CREMATORY Funeral Service Licens 21. Signar 22. Name and Address of Facility MOUNTCASTLE FUNERAL HOME, 13318 OCCOQUAN RD. WBG V 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Myeloid Leukemin **Physician** Cute disease or condition /Medical resulting in death) Chronic Lymphocytic Leukemia Examiner Acute Mycloid Leukemia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the a 2 No Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t director, page 2 autopsy performed 25 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 2 🗌 No 1 Yes 2 Accident investigation death. Director: A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-UUU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, I legistrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23arti per dr. good 100 Amend Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month Physician Nancy C. Dietrich 18, 2010 May 3:02 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medica1 Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan • 26,1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M **X**XF Months Maryland 75 215-32-4044 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 ☐ Yes 🏋 🗖 No Director MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 H Wilrich Circle 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White Completed by XXWidowed 4 Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Injury or other traumatic event, the Medical 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Loan Officer Credit Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland should be fii and Mental H Be Clarence H. Carpenter Evelyn Chilcoat ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health : Paige Koerner / Daughter Skywood Ct. Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Episcopal
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o jo XX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 5/24/10 Glen Arm, MD 21. Signature of Final Se and Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lyocaraia disease or condition resulting in death) /Medical cuns quence of): Due to (or as a Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Physician/Medical 687 Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Yes. 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes Vital 28. Place of Death (Check only one Physician; 25. Was case referred to medical examiner?
1 per 2 □ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ____atient __2 _ ER/Outpatient __3 __ DOA Medical Certification: To Division or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After t Injury 5 ☐ Pending investigation 12 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a the Hospital 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar colo

iled (Month, Day,

DHMH 17 Rev 1/2001

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HARKES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Man		rtificate of D			eg. No.	0 1 0	15743	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	-10				2. Date of Deat Month May	h Pay	2010	3. Time of Death 9:10 p M	
	Medic Examin	al	Mary Elizabeth D 4a. Facility Name (if not institution, give s		4c. County of Death							
		٠.	Morningside Hous			Laurel				Prince George		
	Funeral Director		388-48-7708	7. Age (In	n yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug • 13	Year) 1953	9. Birthp Count	place (State or Foreign try) Wisconsin	
	f show	ctor	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				1	0d. Inside City Limits 1X¥Yes 2 □ No	
	e Mar r 28a- notifi	Director	MD Prince Ge	orge	Laurel	10f. Zip Code			10a Citizen of	Citizen of What Country?		
	with th	Funeral	14504 Cambridge	Circle		20707			USA	rmat ocar	.,,	
3	I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The fire at the and searched other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🖾 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	r in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, e	etc.	
3	nours a	leted	3 Widowed 4 Divorced 15. Decedent's Edu		16a. Dece	edent's Usual Occupa	tion		16b. Kind of E			
3	iin 72 h ie. han "n e Medi	Completed	(Specify only highest grad	College (1-4 or 5+)	life. I	kind of work done do DO NOT use retired)	•	ing	/ Norogr	200		
4	Hygien Hygien Ather t	Be C	17. Father's Name (First, Middle, Last)	4	Purc	hasing Age	18. Mother's Name	e (First, Middle, N	Aerosp			
	l be filk fental l rked c tic eve	10	Norbert Britten				Alice Ki					
a	2 should be th and Ment 27 is marker traumatic e		19a. Informant's Name/Relationship (Typ			ling Address (Street a					(ode)	
ב ט	and 2 Health tem 27 other t		Michael Charles I		20b. Place of Disp	osition (Name of		Date	20c. Location	_	wn, State	
5	Page 1 nent of ant: If i		1XXBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			ematory or other place Mem.Park	⁹⁾ May 2010		Wassau	ı, WI		
Dal	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service License	e M010		22. Name and Addres					, P.A.	
	nysician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as insequence of): Due to (or as a consequence of). Due to (or as a consequence of).									
3	cate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.									
. הטא מס	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death, within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐ Ectopic pregnanc	<i>y</i>			ate of delive	ery Day Year	
5, 7,	uires that the signed by the signed by the details	ρ	Part II, Other significant continuous continuous to death but not resulting in the directlying scales given in act.							e contribute to the cause of death? No 3 □ Probably 4 丛-Unknown		
חביים	The law req ate has bee page 2 shot	Completed						24a. Was a autop perfor 1 □ Yes	sy med?	Were autoprior to codeath?	psy findings available mpletion of cause of 2 No	
Ī	sician; certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	□ 50/0 · · · ·	Othe	r: Check			h (Ci4-	ASSISTED LIVING	
2010	nding Physath. ath. :: After this e funeral di	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Y	28b. Time	of 28c. Injury work	28c. Injury at work? 28d. Describe how injury occurred					
DIVISIO	tal or Atters safter decar Director ed in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (treet, factory, office		28f. Location (S City or Town		ber or Rural	Route Number,	
	Hospi 24 hou Funer leted fill	Medical	(Check 2 Medical Examin	cian: To the best of my er: On the basis of exar e Practioner: To the be	mination and/or inve	estigation, in my opinio	n, death occurred a	it the time, date ar	nd place, and d	ue to the ca	use(s) and manner stated.	
	Vithin comp	2										
			29b. Signature and title of certifier Rica Dhaw 30. Name and address of person who co	ompleted cause of dear	th (Item 23a) (Type 5 Chev)	Print) Welet Dr, S	nite 103,	Ellicol	- City,	MD-	-21042	
	Sta		31. Date filed (Month Day Year) 2010	32. Registrar's	Signature	illed.						

10-03155	
Arnold Epps	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Arnold Epps		I- For State Registrar	Sta	ate of Maryla		epartment o Ce <i>rtificate o</i>		and I	Mental H	-	Reg. No	201	0	1574
Physician Medical Examine	1/	Decedent's Name (F	irst, Middle	ATTO.		Cinley Ep	pes			2. Date of De Month	eath Day	/ Year		3. Time of Death 0945 hrs
wedicai Examine		4a. Facility Name (if no	t institution		et and number) 4b. City, Town, or Location of Death						2010	4c. County of	Death	0945 1115
	ı	4922 Lasalle R	Road				Hyattsvil	le				Prince Ge	orge'	s
Funeral Director	٦	5. Social Security Numl		5. Sex	7. Age (In y	rs. last birthday)	If Under 1		If Under 24Hrs Hours Min.					nplace (State or Foreign ntry)
Director	ŀ	139-56-3		1XM 2F		50 _{Yrs}				12-	-8-	1959		VA
any	ł	Usual Residence of De 10a. State 10b	. County		10c.	City, Town or Local	ion						Т	10d. Inside City Limits
Maryland 28a-f show any 1 at once.	5	MD		na	В	altimor	е							1 X Yes 2 No
the Maryland a or 28a-f sh tified at once		10e. Street and Numbe					10f. Zip Coo	le				itizen of What	Count	ry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once TO Be Completed by European Director	<u>-</u>	5003 LaS	alle	Avenue	edent Ever	in IIS 13 W		206	nic Origin? (Sp	pecify Ves or N		U S A	Americ	an Indian, Black,
r death with or items 23		1 Never Married	2 XMai			lf Y	es, specify Cu	ıban, Me	exican, Puerto		10-	White,	etc.	
after c	<u>-</u>			rced If Yes, Give Yea	r	1		_		- 6		Specify:		lack
"natur	<u> </u>	15. Decedent's Educa Elementary/Seconda		fy only highest grad		d) 16a. Deceder during m			(Give kind of w NOT use retire		16b.	. Kind of Busir	ness/In	^{dustry} unk
5-0036 ed within 72 hour lygene. other than "natu the Medical Exan		12th			na	Fa	ctory	Wo	rker					
15-003 iled withi Hygiene. I other th		17. Father's Name (Firs	st, Middle, L	ast) UNI				18.1	Mother's Name	(First, Middle	, Maide	n Sumame)		
21215-0036 nould be filed within 7 and Mental Hygene, is marked other than tic event, the Medica		19a. Informant's Name/	Relationsh	p (Type, Print)		19b. Mailine	Address (S	Itreet an	Ethel nd Number or F	Eppes	umher (City or Town	State	Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	1	Tondlea 1			-Wife	4.8	•		e Aven			-		
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If iten 27 injury or other traum	Ī	20a. Method of Disposit 1 X Burial 2 \Box (3 Removal fr		Ob. Place of Dispos	ition (Name of	cemete	erv.	Date	20c	. Location - C	ity or T	own, State
Baltimore, Jermit. Pages I ar Department of Het Important: If ite		4 Donation 5	Other Spe	ecify:	Jiii Otato	crematory or ot King M					- 1			town, MD
Balt Permit Depart Impor		21. Signature of Funera	al Service L	icensee)		lame and Add		_{Facility} M North	arch		st F/H		MD 01000
Physician	+	23a. Part I. Enter the di			aused the de							Balto hock, or heart		MD 21202 Approximate Interval
Examiner	l	failure. List only o Immediate Cause (Fina	ıl disease		icatio	ons of bl	unt for	rce	head i	njurie	S			Between Onset and Death
	1	or condition resulting in	n death)	Due to (or as a						•				
	<u>.</u>	Sequentially list conditi if any, leading to immed	flate:	Due to (or es a	consequenc	où ofj:								
0, be executed sician and purial - transit		cause. Enter Underlyin (Disease or injury that i events resulting in deat	initiated	c. Due to (or as a	consequence	ce of):								
50, te be executed ysician and burial - transit				d										
O, e be exc sician burial -		XUNPENDED		XAMENDED 23	a.27.2	28a-f. pe	r ME g	905	7/26/1	O TT				
30x 6876 Jeath certificate e attending phy for use as the b		IF FEMALE: :3b. Was decedent preg past 12 months?	nant in the			,	tal death		Ectopic pregnar		23	3d. Date of de Month	livery Da	y Year
the death certificate by the attending phyched for use as the Physician/M	3	1 Yes 2 No 9	Unkn		ant at time o	of death 5 Ot	her (Specify)							
that the danced by the detached i		Part II. Other significat	nt conditio			ot resulting in the u	inderlying caus	se giver	n in Part I.	23e. Did	tobacco	o use contribu	te to th	e cause of death?
8 20 8	3									1Y	es 2[No 3	Proba	bly 4 🗸 Unknown
w requires been a should											psy	prio	r to co	ppsy findings available mpletion of cause of
Records, The law require, ficate has been sig. page 2 should be	5									perf 1 ✓ Yes	ormed?		th? Yes	2 No
of Vital Records, ng Physician: The law require when this certificate has been si meral director, page 2 should t	8	25. Was case referred t examiner?	_	Hospital:	npatient 2	ER/Outpatient		ace of E	Death (Check o		Deeld	lence 6 🗸	Oth out	P
ing Physi After this funeral di		1 Yes 2	No	28a, Date	of Injury	28b. Time of I		Injury at	1 11010111	28d. Describe			Julei.	ocene
Sion Attending the full by the full cartion.		1 Natural 5	Pendir Investi	9 12/1	Day, Year) 1/2009	unknow	n l 1	Yes	2 X No	sub ie	ct a	assault	ed	
or Ay after of Direc		3 Suicide 6	Could	not be 28e. Place	e of Injury - A	At home, farm, stree	et, factory, offic	e buildi	ing, etc.	28f. Location or Town,	(Street State)	and Number of	or Rura	Route Number, City
y file	ነተ	4 XHomicide 29a. Certifier 1 Cor	determ	(Specify)	roa		rod at the time	doto o		Danvil	Le,	VA		
at a pla	2	1-11-11-11	-	iner: On the basis of and manner st	of examination	_								
To With		29b. Signature and title	of certifier	and mariner si	ateu.	1	29c. Lice				29d.	. Date signed	(Mont	h, Day, Year)
		Call	M	114	1	7	O.	C.M.E			Api	ril 24, 2010	0	
	1	30. Name and address of Zabiullah Ali, M		no completed caus		· ·	n Street. B	altimo	ore, MD 212	201				
State	e :	31. Date filed (Month, D.	ay, Year)		strar's Sign		ale							
Registra	12	The second second	MA OL		la varado.	. 17 180								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 \mathbf{P}^{M} Billie Eaton 5:50 May Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairhaven Health Care Center Sykesville Carrol1 If Under 1 Year If Under 24 Hrs.

Min. Pays Hours Min. 8. Date of Birth (Month, Day, Year) Oct 29, 1915 Social Security Number Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral 1 □ M 2 🏻 F Months 94 Director 396-05-8116 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Sykesville Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21784 USA 7200 3rd Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) healthcare education nursing teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Stella Whiting George William Clayton of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10501 Alcoy Court; Waldorf, Maryland 20603 Department of Health Important: If item 27 any injury or other the once. Martha Brown/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 K Donation 5 ☐ Other (Specify) Sign vuite of Funeral envice Lice ^{22. Name and Address of Facility} Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erebrovasch disease or condition Medical resulting in death) Due to (or as a consequence of ^{*}Examiner Sequentially list conditions, Examiner ir any, reading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy certificate 1 Yes 2 No Yes 2 No or Attending Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation the 1 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and the 29c. License number 29d. Date signed (Month, Day, Year) 34849 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idersburg Williamlan MD 1645 31. Date filed (Month, Day, Year) 32. Regis State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Henry Charles Einolf, Jr. рМ 2310 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Feb. 4, 192 1XXM 2 | F Months Days Hours Min **Director** 217-16-5912 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XXNo MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 9218 Twin Hill Lane 20708 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1XX Yes 2 ☐ No <u>Ş</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 🔀 No Specify Specify: white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Westinghouse Electric Elementary/Seconday (0-12) College (1-4 or 5+) Branch Manager Supply Corporation other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Charles Einolf, Sr. Mary Grossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria P. Einolf/Wife 9218 Twin Hill Lane, Laurel, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State May 20, 4 Donation 5 Other (Specify) 2010 Meadowridge Mem. Park Dorsev. . Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Sten Stiles M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Cardiac arrest Medical resulting in death) Due to (or as a consequence of) Examiner Coronary disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exam the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death detached 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be Gastrointestinal bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary hypertension 24a. Was an has autopsy performed? Yes 2 2 No page certificate | Renal insuffiency 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pendina work? 1 ☐ Yes 2 ☐ No after death Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D0064100 May 14, 2010

State Registrar

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Smitha Bhikkaji, MD,

			ľ	For State Registrar	State of Marylan		tificate of L		wiental H	ygiene Reg. No	2010	1574
		Physicia Media		1. Decedent's Name (First, Middle, La	ALMER SR.				2. Date of D	eath	y 2010	3. Time of Death
(Examir		4a. Facility Name (if not institution, give SINAI OSPITAL	e street and number)		4b. City, Town, or	r Location of Deat	h	4c.	. County of Death	
		Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 A						9. Birth Cour	place (State or Foreign	
		Maryland 28a-f show stified at	rector	10a, State 10b. County		7, Town or Loc						10d. Inside City Limits
		with the 23a or 2 sst be no	Funeral Director	10e. Street and Number 1521 5+01	VE WOOD RD.		10f. Zip Code	ì			izen of What Cou	ntry?
MEL	9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status i Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 112 Yes 2 No If Yes, Give Year or Dates.		/as Decedent of Hi Yes, specify Cuba		pecify Yes or No o Rican, etc.))-	14. Race - Americ Black, White, Specify: BLA	etc.
THEMER	Maryland 21215-0036	within 72 hou giene. ier than "nat ier the Medica	Completed by	15. Decedent's Elementary/Seconday (0-12)		(Give k	ent's Usual Occupind of work done of NOT use retired)	during most of wor	rking		ind of Business In	dustry
JOSEPH	yland 2	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) RAYMOND FARMER	3			18. Mother's Nan				
		nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (7 SEANNETTE WHITE/	ype, Print) SISTER	19b. Mailing	Address (Street a	and Number or Ru WもOD QA	ral Route Numb		Town, State, Zip o	_
N AS	Baltimore,	Page 1 ar tment of He tant: If iter jury or oth		20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Control	Removal from State	lace of Disposemetery, crem	ition (Name of atory or other plac Foliation	ce) 5/21	Date	20c. Lo 1150	ocation - City or To I GACK SC JGS MILL	own, State N FOREST S, ND 2117
KNOWN	Bal	permit. Page Department of Important: It any injury or once.	V)	21. Signature of Funeral Service Mens	Mont	2	Name and Addres	ASTEDIU	AVE.	AVIS,	JR, FURL	-, HM. SZ1231
A TY	J	Physician/ Medical Examiner	ər	23a. Part 1. Enter the disease, of comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Affunsclur Due to (or as a consequence).	ofu() ence of):	the mode of dying	g, such as cardiac		urrest,	,	Approximate Interval Between Onset and Death
ly	2 0948	finate be executed g physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any leading to the model cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence) d.						(.	
		ji bes	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 aeath 5 ae	Other (specify)			2	23d. Date of delive Month	ery Day Year
	ds, P.(quires that en signed uld be del		Part II. Other significant conditions of	ontributing to death but not resu	Ilting in the un	derlying cause give	ren in Part I.				ne cause of death? bably 4 Unknown
	of Vital Records,	: The law rec cate has be page 2 sho	Completed by	- 1121							prior to col death?	osy findings available mpletion of cause of
	Vital	Fnysician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🖼	R/Outpatient		ace of Death (Checer: 4 Nursing H		idence 6	Other (Specify,)
	on of	tending Pn death. stor: After thi the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b.	(Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆 `		28d. Describe I	how injury	occurred	
	Division	o the nospital of Attent within 24 hours after death To the Funeral Director: , completed filled in by the		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tov	wn, State)	Number or Rural	
	:	no the Hospital within 24 hours a To the Funeral C completed filled	Medical	only one 3 Certifying Nurs	sician: To the best of my knowle ner: On the basis of examination se Praction: To the	and/or investig	ation, in my opinior	n, death occurred a time, data and pla	at the time date a	and place	and due to the call	ise(s) and manner stated
3)		0 1 wit		29b. Signature and title of certifier Well Well Well Well	thus		29c. License	3375		05/	signed (Month, I	
		ϕ		30. Name and address of person who o	ompleted cause of death (Item 2	23a) (Type, Pri	VE BA	LTIHOIL	F, MD	212	209	
		Stat Registra	e r	NAY 20 2010	32. Registry's Signat		A Shirt	- E				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fountain Carol 2010 Betsy May 8:20 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 1902 Furnace Road Jarrettsville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Min. Hours ^{Year)} 1941 July 24 West Virginia 218-40-4855 68 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Md. Harford Jarrettsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 USA 1902 Furnace Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Deeds Carlene Woods Carl Milton Lois 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 302 Clarksville, Md. 21029 Mr. Anthony Pileggi/ Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 5-21-10 4 ☐ Donation 5 ☐ Other (Specify) ake View Mem. Park Sykesville, Md. 21. Signature of Juneral Service License ^{22. Name and Address cikacitowson Funeral Home, Inc.} 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Approximate Interval Between Zyears Immediate Cause (Final multi multiple
Due to (or as a consequence of) Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 ed by the a s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kidney Stones, hypertension Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s autopsy Hospital or Attending Physician: The Yes 25. Was case referred to medical examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ed cause of death (Item 23a) (Type, Print) erson who comple Jarrettsville, MD 2,084 lleRd NOMISVI

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Mav <u> Oiu Ying Fang</u> 3:39 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. Director Yrs 219-98-2558 China 80 Au'a'' Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Germantown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18003 Mateny Road 20874 #300 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 2 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Chinese If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) and Mental Hygiene. Chemist State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, မ Zhe Min Fang traumatic Ju Fena Li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant; If item 27 is Yuning Qu 225 Shadow Glen Court; Gaithersburg, MD 20878 other son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Important; If it ò injury 4 Donation ☐ Other (Specify) Dulaney Valley Mem Gardens 5/22/2010 Timonium, MD . Signature of Juny Serv any in once, 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home. Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Malignant pleural effusion Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury Metastatic breast carcinoma and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown ğ Pregnant at time of death Month Day per 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director. Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) this 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

To the I within 2

(Check

only one)

29b. Signature and title of certifier

Sonia John, MD 31. Date filed (Month, Day, Year)

metro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day. Year)

5/17/10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

9901 Medical Center Drive; Rockville, MD 20850

29c. License number

D0067386

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 17 & 18 per Fh & 30 per DVR g903 5/20/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. --1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2010 lЬ /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death City, Town, or Location of Death Examiner anda 9. Birthplace (State or . Country) POLAND 7. Age (In vrs. last hirthday Date of Birth (State or Foreign Number **Funeral** Months Days Hours Min 1271471924 213-30-5008 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evancium 1. set the perifical as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No BALTIMORE RANDALLSTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3701 SHELLBROOK COURT 21133 12, Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🚺
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No Specify Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER HAULING 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN . UNKNOWN FREUNDLICH ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 SHELLBROOK COURT, RANDALLSTOWN, MD 21133 GRETA FREUNDLICH/WIFE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State BALTIMORE HEBREW CEM : 5/18/2010 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MĎ 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course o Medical (Check only one) Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated rtifie 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Everette Darr LaFon, Jr. MD Northwest Hospital, Randallastown, 32 Registrar's Signatu 31. Date filed (Month, Day, Year) State 20 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygiei	2010 15751
100	Physic /Med		1. Decedent's Name (First, Middle Las	lan Friedma	n	2. Date of Death Month	Day Year Scoa M
	Exami		4a. Facility Name (If not institution, give CHAPEL HILL CONVAL	ESCENT CENTER	4b. City, Town, or Location of Dea		4c. County of Death BALTIMORE
	Funeral Director		5. Social Security Number 6. Se 215-20-9974 10 Usual Residence of Decedent	7. Age (In yrs. last birth	Months Days Hours Min		ar) 9. Birthplace (State or Foreign Country) MD
	e Marylan 3a-f show	ctor	MD BALTIMO	DRE BALTI			10d. Inside City Limits 1 □ Yes 2 🛣 No
	th with the	al Dire	10e. Street and Number 3702 PINELEA ROA	AD.	10f. Zip Code 21208	10g.	Citizen of What Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	within 72 h lene. 'then "natu the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (ecedent's Usual Occupation Sive kind of work done during most of wo fe. DO NOT use retired) BOOKKEEPER	orking 16b.	Kind of Business/Industry PLASTICS
Maryland 2	S should be filed with and Mental Hygiene. Is marked other ther aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) CHARLES	KR00P		me (First, Middle, Maid	
ď	1 and 2 should Health and Mer am 27 is marke ther traumatic		19a. Informant's Name/Relationship (7) KAREN FISHER/DAUG	GHTER 40	Aailing Address (Street and Number or R 8 N. MAPLE DRIVE,	APT A, BEVE	RLY HILLS, CA 90210
Baltimore,	it. Page ntment o rtant: If njury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licens	BENEFIC		18/2010 B	BALTIMORE, MD
Ba	Depa Impo		Kresto /	1	8900 REISTERSTOWN	ROAD, PIKE	I & BROS., INC. SVILLE, MD 21208
J. Comments	Physician /Medical Examiner portion and p	Examiner	23a. Part1. Enter the disease, or comples shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)		con respiratory arrest,	Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed te has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ Unknown	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that i been signed by should be deta	र्व	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably
		Completed				24a. Was an autopsy performed?	
	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes	lospital:	0.1	ath Check only one	
Division of	5 E	ation: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ ER/Outpatent 2 ☐ ER/O	e of 28c. Injury at	dome 5 Residence 28d. Describe how in	
Divis	i Dife	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
:	in the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Crack of the control one) 29b. Signature and title of certifier	sician: To the best of my knowledge, dier. On the basis of examination and/oand manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	irred at the time, date a	nd place, and due to the cause(s)
	N N) ap, comp		29c. License number R125808		Sate signed (Month, Day, Year)
er a	Sta Begistr	te	30. Name and address of person who co Amore L. V. Lleve 31. Date filed (Month, Day, Year) MAY 2.0 2010			धीर टेट्डे र	Posis OM, oth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** IWVIA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country)
_ If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/16/1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** Maryland 212-78-3165 50 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Baltimore MDN/A10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21205 U.S.A. Funeral 528 N. Luzerne Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X**] No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Is marked other than "natu aumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Contractor DCMA Maryland years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Harrier Gundy Reginal Howard ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and 2 Department of Health ar Important: If item 27 Is any Injury or other trauonce. Luzerne Ave., Baltimore, MD 21205 528 N. Walter Puckett(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/25/10 Baltimore, MD King Mem. Park 22. Name and Address of Facility 21. Si natur of Funeral Service Licensee Joseph Hrulton Ave: , Bullimore, MD 21217 23a. Part 1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Couse (Final Approximate Interval Between Onset and Death **Physician** Sepsi5 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 2 No ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury this ineral Director: After this filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Yes 2 No 2 Accident after death 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number CON ٩ MD Dd

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AY 2.0.2010 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Konerna

600 North Wolfe St, Baltimore, MD, 21287

		•	For State Registrar		State	of Mary			artment of I tificate of I		and M		giene Reg. N	ZUI	0	15	753
_	/sicia /ledic		1. Decedent's Name (F	First, Middle, L	ast)	(·		Hanr	nahs		2. Date of De)10	3. Time o	
	amin		4a. Facility Name (if no 8724 Little			nber)			4b. City, Town, o		of Death			County of		1	
Fun Dire	eral ctor		5. Social Security Num 213-01-9652	ber 6.	Sex 1		yrs. last birth	nday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir	th			place (State try) MD	or Foreign
yland -f show	ed at	ctor	Usual Residence of De 10a. State 10	ecedent Ob. County Baltimo	20	10	c. City, Town		cation						1	0d. Inside 0	
ith the Mau 3a or 28a	t be notif	ral Director	10e. Street and Number	ər			Laikvi	116	10f. Zip Code				_	itizen of Wha	at Coun		es 2 🔯 No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	aminer mus	by	8724 Little 11. Marital Status 1 Never Married	2 Married	12. Was Dec	rces?	in U.S.	11	Vas Decedent of H Yes, specify Cuba	an, Mexica	in, Puerto	cify Yes or No- Rican, etc.)	U.	S.A. 14. Race - A Black, V			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", o	Aedical Ex	Completed	(Specify	5. Decedent's only highest	If Yes, Giv Year or D Education grade completed	ates.		Deced (Give k	Yes 2 X No	ation		ing	16b. k	Specify:	Whi less Inc		
id 212 lled within I Hygiene.	rent, the N	Be	Elementary/Second 9 17. Father's Name (First		College (1	-4 or 5+)		e Ma	NOT use retired) aker		ner's Name	e (First, Middle,		Own Hom	ne		
arylar nould be fi nd Mental	umatic ev	욘	John 19a. Informant's Name	e/Relationship	Type, Print)		- 1		reuther g Address (Street	Kath	nerine				Zin C	Call	hon
re, Mar 1 and 2 st f Health a item 27 is	other tra		Sharon K. Sm. 20a. Method of Dispos	ition			41 20b. Place of	00 G	reenway, E	altimo	ore, M			ocation - Cit			-
altimo nit. Page vartment o ortant: If	injury or e.		1 🔀 Burial 2 🗌 4 🔲 Donation 5 21. Signature of Funera	Other (Spe	cify)		-	Val	natory or other place ley Memoria . Name and Addres	al	05/20 _/			monium, Ruck, I	-	yland	
Dep nam	any	4	23a. Part 1. Enter the	ardia	BRO	caused the	death. Do no	53	305 Harford	Road,	, Balt	imore, M	212	14	inc.	Approxima	
Physic Med			shock, or heart fa Immediate Cause (Fin- disease or condition resulting in death)	allure. List only	one cause on ea	ach line.			HEART							Interval Be Onset and	tween
Exam		Jer	Sequentially list condi-	ulate	D		TEN Insequence of		ON						\perp		
760 cate be executed physician and	ial-transit	Examiner	cause. Enter Underlyir Cause (Disease or iinjuthat initiated events resulting in death) Las	ury	c. Due to	(or as a co	nsequence of	ŋ:							+		
8760 ifficate be	as the bu	Medical	IF FEMALE:		d												
Division of Vital Records, P.O. Box 68760 Ital or Attending Physician: The law requires that the death certificate be executed rs after death. In the certificate has been signed by the attending physician and birector. After this certificate has been signed by the attending physician and	ched for use		23b. Was decedent pre in the past 12 mor 1 Yes 2 N 9 Unknown	nths?		Birth 2 L nant at tim	Fetal death		Ectopic pregnand Other (specify)	у				23d. Date of Month		-	Year
S, P.O	ild be detac	<u>ا ۾</u>	Part II. Other significa	RATI	Ry +	FAIL			nderlying cause giv	en in Part	1.	1		use contribut			
Vital Recorc sician: The law req certificate has bee	page 2 shou	Completed	Suit	PA	PNEA							24a. Was a autop perfo	sy rmed2	prior deat	to con	sy findings npletion of a	available cause of
Vital vysician:	ector	To Be (25. Was case referred t examiner? 1 □ Yes 2 □	•	Hospital:	Inpatient	2 🗆 ER/Out	patient	_ Oth	ar.	ath <i>(Check</i> ursing Hor	only one)	lence 6	i □ Other (S	pecify)		
On of ending Pr eath. or: After th		Certificate:	2 L Accident	☐ Pending Investigation	on .	of injury th, Day, Yea	ar) 28b. Tii	me of ury	28c. Injury work M 1	at .	2	28d. Describe h					
DIVISI ospital or Att hours after d ineral Direct	0		4 Homicide	Could not determined	buildi	ng, etc. (Sp	ecify)		et, factory, office			28f, Location <i>(S</i> C <i>ity or Tow</i>	n, State,)	r		ber,
the Hospital of the Police a man 24 hours a me Funeral D	mpleted t	Med	(Check 2 🖳	Medical Exar Certifying Nu	niner: On the bas	is of exami	nation and/or	investi	gation, in my opinic eath occurred at the	n, death o	ccurred at	the time, date a e, and due to the	nd place e cause(s	, and due to to and manne	the causer as sta	se(s) and ma ited.	anner stated.
	3		Alla	- (L-				29c, License	107	6		5/1	te signed (M	10	ay, Year)	
(2		30. Name and address ORN EL.	of person who	Gompleted caus	e of death	(Item 23a) (Ty	/pe, Pr	int)	. 0	zeti	, Mo	217	237			
Reg	State gistra	e r	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORN EL. ASSON GLOG CH. (Edun h.: R														

10-03664 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jamie Lee Hawkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day May 12, 2010 Medical Examiner 1327 hrs Jamie Lee Hawkins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Director 2**X**F 1 M 52 08/06/1957 NewtyJersey Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must he notified at once. Essex Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Apt G Brighton Manor Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married 2 No Yes imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Com Beth Steel Security 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be <u>James Coffee B</u>right Hattie Lucille Doggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Shay Murchison ′Niece 416 Sugarberry Ct Edgewood. Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify Baltimore Crematory 5/24/10 Baltimore, Maryland 21. Signature of Funeral Service 🕦 nsee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland Part I. En or the disease, or failure. Ust only one caus the disease, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 딜 Physician/Medical tending physician a X UNPENDED AMENDED 23a, PII, 27, per ME G904 6/14/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≧ 1 Yes 2 No 3 Probably 4 V Unknown Obesity Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 performed? death? certificate Yes 2 V No 1 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) director, Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Pending Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City within 24 hours after 3 Suicide 6 Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 13, 2010 Ol

DHMH 17 Rev 1/2001 **OCMF 2006**

State Registrar

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:52 P.M Physician a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 F Director 423-38-5829 76 10-3-1933 PITTSBURGH. PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 1 Yes 2 No Directo PA. LANCASTER HOLTWOOD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 1173 HOLTWOOD RD. 17532 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) l other than "natur vent, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NASA PHYSICIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EARL W. HICKS SR. NANIE HICKS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY STOUTZENBERGER (WIFE) 1173 HOLTWOOD RD. HOLTWOOD, PA 17532 Department of Heal Important: If item 2 any injury or other once. 20a. Method of Dispos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5-22-2010 1 🗌 Burial 2 5 Cren 3 Removal from State 4 Donation her (Specify) EVANS CREMATORY SERVICE LEOLA, PA 21. Signature of HIBNER^{2. Name and Address of Facility} CLYDE W. KRAFT FUNERAL HOME INC D. MAHTANOT 519 WALNUT ST. COLUMBIA, PENNA 17512 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme rate Cause (Fi disea e condition resulting in death) Cause (Final Dulmonar **Physician** Idio pathic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached P.O. 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has 1 Tyes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

AYAM

31. Date filed (Month, Day, Year)

ORIGINAL

address of person who completed cause of death (Item 23a) (Type, Print) WIDHASSEL

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

29c. License number

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Joseph Valentine Hartman, Jr. 2010 May 10:19 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil 1745 Conowingo Rd Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Maryland **Funeral** 1 XM 2 □ F Days (Month, Day, Months Hours Director 52 1958 218-74-0889 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Cecil Rising Sun 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 1745 Conowingo Rd 21911 items ; 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 9 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene.
27 is marked other than "
traumatic event, the Mec life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Public Works Be permit. Page 1 and 2 should be filed villed beathment of Health and Mental Hyg Important: If item 27 is marked othnany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph V. Hartman, Sr. Margaret Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hartman / Brother 609 Cole St., Perryville, MD 21903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Comp. 5/19/2010 West Chester, PA 21. Signature of Funeral Service Licensee any in Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 Kirste 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or iinjury that initiated events burial-transi Onan resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 Yes 2 No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🔀 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5X Residence 6 Other (Specify) s after death. filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) son who completed cause of death (Item 23a) (Type, Print) 01 00 FE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed /M

210

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2010 Betty Jo Helmer May 18 6:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Meade Road Lot Laurel Anne Arundel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Tennessee 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours 69 Yrs Director 224-54-8460 Usual Residence of Decedent 28a-f shor 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Anne Arundel Laure1 10e, Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 3285 Fort Meade Road Lot 20724 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gifford Tolliver Maude Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other trai Kenneth Helmer / Husband 3285 Fort Meade Road Lot 6 Laurel, Maryland 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel_Crematory 05-19-2010 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, 23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oronar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death the g Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitus iabetes Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypestensi-24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗷 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) No M Natural 5 Pending within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and the of certifier 45660

State Registrar

DHMH 17 Rev 7/2009

ath (Item 23a) (Type, Print)

strar's Signature

ress of person who completed cause of

2010

MAY 20

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ANTHONY 4:30 PM MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COUNTY GENERUAL HUWARD HOSPITAL Councia Itowa RD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 30 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Director 217-44-3057 Maryland 63 1946 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Laurel Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral All Saints Road 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White "natural", 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11th Truck Driver S & G Concrete Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Anthony Hall, Sr. Hazel Lucinda Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy L. Hall/Spouse 9259 All Saints Road, Laurel, Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State / injury 4 Donation 5 Other (Specify) West Arundel Crem. 5/19/2010 Odenton, MD Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 22. Name and Address of Facility M01053 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC ESSPINACIOAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIAZ 4 my surant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (u. as a consequence ui) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit PNEUWOPERI CAMPIUM 2 WEEKS that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 □ No 9 Unknown detached 9 Unknown Division of Vital Records, P.O. ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 Xio 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 Mpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

el

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign ture

29c. License number

U. NYANJOM MO, 10710 CHARTER DR SUITE 310, COLUMBIA MO 21044

036974

29d. Date signed (Month, Day, Year)

MAY 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year LEE HEFFNER MAY 18 2010 12:13A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner

1 - For State Registrar

GARY

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marilcal Examinal mast bear trained.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed the aftending physician and thed for use as the burial-tran been signed by the should be detached s certificate has be irector, page 2 sl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

	WASHINGTO	ON ADVEN	TIST HOSPI	ral_				A PARI				MONT	GOM	ĒRY	
	5. Social Security N 577-68-76	520	Sex 7. Ag 1X M 2 □ F	je (In yrs. I 61	ast birthday, Yrs.	Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I JULY	Dav. Yea	ar) 948	1 (irthplace (State Country) HINGTON	
	Usual Residence of	Decedent 10b. County		10c City	, Town or Lo	ocation								10d Inside (Nitra I Impia
ō	111.5	1				Jealion								10d. Inside (
Funeral Director	MD	Anne A	rundel	L	aurel										2 X No
늞	10e. Street and Nur					10f. Zi	ip Code				10g.	Citizen o	f What C	Country?	
<u>a</u>	3624 Lau	rel View	v Court				207	724					USA		
l le	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Dece	edent of H	ispanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	10-		ace - Am ack, Whi	nerican Indian,	
by F	1 Never Marri	ied XX Married 4 □ Divorced	1 ∐Yes 2 ½ If Yes, Give Year or Dates:	No		1 □Yes		Specify:		,		Spec		White	
Completed by		15. Decedent's E	rade completed)		16a. Dece (Give	edent's Usu kind of wo DO NOT u	ual Occup ork done o use retired	ation during mos	t of worki	ing	16b.	Kind of	Busines	s/Industry	
Com	Elementary/Seco 12t		College (1-4or !	5+)		ts Pu						NAP	A		
Be	17. Father's Name	(First, Middle, Las	st)			18. Mother's Name (First, Middle, Maiden Surname)									
မ	Stephen	Lee Hef	fner			Edna Huntzberry									
n	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Addres	s (Street	and Numbe	er or Rura	al Route Num	ber, Cit	y or Tow	n, State,	Zip Code)	
	LaVonne	K. Heffr	ner/Wife		3624	Laı	ırel	View	Cour	ct, La	ure	1, M	D 20	724	
	20a. Method of Disp			20b. Pl	ace of Dispo	osition (Na matory or	me of other plac	e)		Date	20c.	Location	- City o	r Town, State	
		☐ Cremation 31 5 ☐ Other (Spec	Removal from State		st Aru			i	/23/	2010		dent	on	MD	
	21. Signature of Fu	neral Service Lice	ensee								Fii	nera	1 Hc	ome, P.A	
ļ. U	Kh	MINOS	M0110				t Ave			_		207			
8 1	23a. Part1. Infer the shock or nea Immediate Suse (disease or condition resulting in death)	rt failure. List on! (Final		ne. epsis	5	ter the mo	de of dyir	g, such as	cardiac (or respiratory	arrest,			Approxima Interval Be Onset and	tween
	,	- (Due to (or as												
-	Sequentially list cor	nditions,	b		rditi	S									
nin.	Sequentially list cor if any, leading to im Cause (Disease or	rlying injury	Due to (or as	a consequ	erice or):										
xan	that initiated events resulting in death) L		c Due to (or as	2 0000000	once of):										
a E			Due to (or as	a consequ	ence on.										
g			d												
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 1 □Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	⊒ Ectopic _[⊒ Other <i>(s</i>							ate of de		Year
유	Part II. Other signif	icant conditions	contributing to death b	ut not resu	Iting in the u	nderlyina o	cause give	en in Part I		23e. Did	tobacc	o use cor	ntribute 1	to the cause of	death?
			nal Failur											Probably 4	
Set	Diab	etes Mel	litus							24a. Was	s an	24b	Were a	utopsy findings	available
Completed					an exami		auto	opsy formed? 2 🔀	,	prior to death? 1 ☐ Ye	completion of	cause of			
Be							Louis		of Death	(Check only	one)				
은								4 ∟ Nu		me 5□Res				ecify)	
ation	1 X Natural 2	5 ☐ Pending investigation	(Month, Da	y, Year)	28b. Time o Injury	f M	28c. Injur Work 1 □ '	∕at ? ∕es 2∐1		28d. Describe	how in	jury occu	rred		
ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At hor c. (Specify	ne, farm, str	farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					nber,				
dical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, on the basis of examination and/one and manner stated.					h occurred vestigation	at the tir	ne, date an pinion, dea	nd place, th occurr	and due to the	e cause , date a	e(s) and r	nanner a , and du	as stated. le to the cause(s)

State Registrar 29b. Signature and title of certifier

Dpinder

31. Date filed (Month, Day, Year)

MAY 20 2010

MD

14300 Gallant Fox Lane,

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Suite 124, Bowie, MD 20715

29d. Date signed (Month, Day, Year)

010

			1- State of Maryland / Depa State of Maryland / Depa Registrar 26 per verb., g903,057	rtment of Health and I 120/1010dhb ifficate of Death	Mental Hygie	ene _{J. No.} 2010 5760
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Henry Jacobson, Jr.		2. Date of Death	4 ^{Day} 201 ^{©ar} 11:57 A м
	Examir		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Death	•	4c. County of Death
7 4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Baltimore 9. Birthplace (State or Foreign
	Director ≥		Usual Residence of Decedent		Apr. 23	1920 Mary Tand
	aryland la-f sho ified at	Director	10a. State	ation		10d. Inside City Limits 1 ☐ Yes 2 X No
	vith the M 23a or 28 st be not	ral Dir	10e. Street and Number 9004 Old Harford Road	10f. Zip Code 21234	100	J. Citizen of What Country?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	1 ☐ Never Married 2 ☐ Married Armed Forces? If	I as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes 2X☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	vithin 72 hou jiene. er than "nat the Medica	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupation nd of work done during most of work NOT use retired) 1ical Engineer	ing	ngineering
yland	id be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Henry Jacobson, Sr.	18. Mother's Nam Anna Mar	e (First, Middle, Maid ie Yost	den Surname)
, Mar	nd 2 shoul lealth and I m 27 is m her trauma		Barbara Polski / Daughter 9004 (Address (Street and Number or Rura Old Harford Road		
Baltimore,	t. Page 1 a tment of H tant: If ite ijury or oth			ley Mem. Gans. May 1	8,2010 T	c. Location - City or Town, State imonium, Maryland
Bal	permit Depar Impor any in			Name and Address of Facility Ruc 50 York Road Tow		
	Medical bhysician and bhysician and the burial-transit the burial-tran	al Examiner	23a. Part 1. Enter the disease, or confileations that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list number of the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	the mode of dying, such as cardiac of) T	Approximate Interval Between Onset and Death Two hearth
Records, P.O. Box 68760	To the hospital or Attending Physician; The law requires that the death certificate by within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the bound the completed filled in by the funeral director.	Physician/Medical	d	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.0	nres that t signed b	6	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Record	The law require ate has been si page 2 should b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
ita I	rsician; s certific director,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check		e 6 ☐ Other (Specify)
Division of Vital	ending Physath. It: After this ne funeral o	Certificate: T	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)		28d. Describe how in	
Divisi	ital or Atte		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		City or Town, St	·
	thin 24 hou thin 24 hou the Fune impleted fil	Medical	29a. Certifier (Check (Check only one) 1	ation, in my opinion, death occurred at ath occurred at the time, date and plac	the time, date and pl e, and due to the cau	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.
D	5			29c. License number 92	8 N	Date signed (Month, Day, Year) May 14 2010 JeBa) Timbre Manyland
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	Nest Belvere	eAKK	1eBa) Timore Manjano
	Stat Registra	-	31. Date filed (Month, Day, Year) A Y 2 0 2010 32. Registrar's Signifure			Ź

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0.5 2010 റ് 07:32 Medical 4a. Facility Name (if not institution, give street and nu **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 4-17-9. Birthplace (State or Foreign **Funeral** Director -1959 Usual Residence 10a. State 10b County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Balto na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2219 Tucker Lane 21207 U S Apt B 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. "natural", Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+)
Master's Drug Rehab 2th grade Counselo other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Janis Jackson Vincent Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Maple Shade Drive Balto, MD 21213 Angela Keene-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5-21-2010 Owings Mills, MD Garrison Forest 4 Donation 5 Other (Specify) Signature of Fundal Service L 22. Name and Address of Facility
March F/H West 4300 Wabash Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresployed, or heart failure. List only one cause of the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 98b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only or 29b. Signa 29d. Date signed (Month, Day, Year)

State

CHMH.17 Fish: 7/2009

Registrar

			1 - For State Registrar	State of M	aryland		artmen rtificat			and Mo		giene Reg. No.	010	15762
	Physici	3	1. Decedent's Name (First, Middle, Las								Date of De Month	Day	Year	3. Time of Death
	/Medi			Needh	am W	. Jor	nes,	Sr			5	13	2010	1:30 PM
	Examir		4a. Facility Name (If not institution, give	street and number))		4b. City,	Town, or	Location	of Death		4c. C	ounty of Death	
30			Future Care	Northpo	oint_		Dui	ndal	k	0.11		В	alto	
	Funeral		5. Social Security Number 6. Se	ex 7. Ag		as <i>t birthd</i> ay) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da 5-3-	th y, Year)	9. Birthp Cour	place (State or Foreign
4	Director		226-12-6343 Usual Residence of Decedent	•	104	113.					5-3-	1906		N.C.
	and w		10a. State 10b. County		10c. City	, Town or Lo	cation						1	I0d. Inside City Limits
	Aaryl en	ō	MD Ba	lto										1 ☐ Yes 2 ☑No
	28a-	ect	10e. Street and Number	100	Dun	dalk	10f. Zip	Code				10a Citize	n of What Cour	ntry?
	with a	ā						2122	2				S A	,
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow he Maulgal Exandrat numblike mullied at	Completed by Funeral Director	4支 Robinson A	venue 12. Was Decedent	Ever in U.S	5. 13				gin? (Spe	cify Yes or No		. Race - Americ	can Indian.
10	ter d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces	?						cify Yes or No Rican, etc.)		Black, White,	
336	urs a	by I	¥☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 X) No	Specify:			S	pecify: B	Black
21215-0036	2 hor	ted	15. Decedent's Ed	ucation	Ì	16a. Dece	dent's Usu	al Occupa	ation			16b. Kind	of Business/In	dustry
215	hin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) Coltege (1-4or	5+)	(Give	kind of wo DO NOT u	ork done d se retired	<i>during</i> mosi)	t of workin	19	Mar	s Supe	rmarket
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	should be filed within ind Mental Hygiene. marked other then "umatic avent, the Me.	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden Si	umame)	
<u>a</u>	should b nd Menta n marked umatic a	Tof	Frank Jones						Jea	nett	e Hol	lowa	У	
Maryland			19a. Informant's Name/Relationship (7	урө, Print)		19b. Maili	ng Address	s (Street a	and Numbe	er or Rural	Route Numb	er, City or 7	own, State, Zip	Code)
	ss 1 and 2 of Health a item 27 ic		Mary Wikson-Da	ughter		41 F	Robir	nson	Ave	nue	Dund	alk,	MD 21	222
ore.	of He		20a. Method of Disposition			ace of Dispo	sition (Na	me of			ate		tion - City or To	
Ē	Page nent c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1 1	lly E				5-19	-2010	Mi	ddleri	ver, MD
Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		21. Signature of Funeral Service Licen	spe		22	2. Name ar	nd Addres	s of Facilit	ty	March	Eas	t F/H	
m	Depa Impo eny ii		KA Clas	1		10.	1101	L E.	Nor					21202
			23a. Part1 Enter the disease, or comp shock, or heart failure. List only	plications that cause	d the death	. Do not en	ter the mod	de of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final	ATHER		7 3 7 1	1	An ni	OVAS C	NIA	m r	NSEP	7-5	Onset and Death
4	/Medical		disease or condition resulting in death)	a. // / / / Due to (or as			<u> </u>	r)ICI) I	0 47/3 (.,,,,,	1501	50	
	Examiner													
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):	•							
	outed ansit	Examiner	Cause (Disease or injury that initiated events	C									1	
ó	en ar	Ex	resulting in death) Last	Due to (or as	a consequ	ence of):								
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99	The law requires that the death certificat ate has been signed by the ettending phy bage? should be detached for use as the	led												
Box	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic p	rennancy				23	d. Date of delive	,
<u> </u>	dea ne ett ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a 9☐ Unknown			Other (s					- Anna -	Month	Day Year
P.0	at the by th stach	Physician/Med	9 ☐ Unknown	3LI OTIKIOWIT										
s,	uires that the de signed by the e Id be detached f	by F	Part II. Dther significant conditions of	ontributing to death t	but not resu	Iting in the u	inderlying o	cause give	en in Part I		23e. Did t	obacco use		he cause of death?
Records,	w requir been si should I										1 🗆	Yes 2□	No 3 ☐ Prot	bably 4 donknown
S	aw re	Completed									24a. Was		24b. Were auto	opsy findings available
Ä	sician: The lav certificate has irector, page 2:	Eo									perfo	ormed?	death?	
Vital	an: rtifica tor, p	a)	25. Was case referred to medical						26. Place	of Death	(Check only o			
\geq	Attending Physician: or death. ector: After this certification in the funeral director.	To B	examiner? 1 🗆 Yes 2 💽 No	Hospital: 1 Inpati	ent 2 🗆 E	ER/Outpatier	nt 3 D	Oth	9r: 4 1 Nu	irsing Hon	ne 5 Resi	dence 6 [□Other (Specil	fy)
ot	g Physical dispersal di		27. Manner of Death	28a. Date of Inju	ury	28b. Time o	f :	28c. Injun	at at		8d. Describe			
<u>o</u>	nding Fath. r: After re funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay / 6a//	IIIIquiy	М		Yes 2 🗆	No				
Division	i or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of In	jury - At hor	me, farm, st	reet, factor	y, office		2	8f. Location (Street and	Number or Rura	al Route Number,
Ö	s afte	Cert		Duilding, e	ic. (Opecity)	,					Ony or ro	mi, State)		
	To the Hospitei or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best	of my know	viedge, deat	h occurred	at the tin	ne, date an	nd place, a	and due to the	cause(s) a	nd manner as s	stated.
	n 24 he Fi	Medicai	one) 2 medical exam	and manner s	tated.	ion and/or in	vestigation	i, in my o	oinion, dea	ith occurre	ed at the time,	date and p	lace, and due t	o the cause(s)
	To the Hospitei within 24 hours a To the Funerel Completely filled	Σ	29b. Signature and title of certifier	\cap			29	c. License	number			29d. Date	signed (Month,	Day, Year)
			Jeffy Worland,	V)				D	30604	60		MA-1	18.21	20
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)			-		1	His Sales and	
-			PANICHO ICHETER	1AL 9	106, P	HIAN	2PH	A	KD A	= 208	, BA	LTIM	18,20 196, M	D
1.2	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat			0						
- 6	Regist	rar	MAY 20 2	nin A.	lead a	1 1	Barks							

DHMH 17 Rev 1/2001

			State of Maryla State Registrar		irtment of H tificate of D			iene leg. No. 2 (10	15763
			Decedent's Name (First, Middle, Last)				2. Date of Deat	:h		3. Time of Death
	Physicia Medic		DOROTHY M. JONES				Month May	Day 15 2	Year 2010	3:15 A ^M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I	Location of Death			y of Death	
-			Gilchrist Hospice Care			son			imore	
	Funeral		1 M 2 W F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 29	Year)	Count	lace (State or Foreign
	Director		160-18-1057 88	115.			June 29	1921	Penns	ýlvania
	show	ъ		City, Town or Loc	ation				10	Od. Inside City Limits
	Aaryla 8a-f	Director	MD Howard	Clarks	ville					1 ☐ Yes 2 🛛 No
	the land a or 2		10e. Street and Number		10f. Zip Code	-		10g. Citizen of	What Coun	try?
	ıs 23a ıust I	Funeral	7221 Tall Pine Way		2102				USA	
	death item ner n		11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - America ack, White, e	
36	after Il", or xami	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced The Wes 2 No If Yes, Give Year or Dates,	1	☐ Yes 2X No	Specify:		Specif	y: Wh	ite
9	within 72 hours after death with the Maryland glene. Ethen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occupa	tion	- 1	16b. Kind of I	Business Inc	lustry
215	e. Ban "r Med	Ĕ	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)		aind of work done du O NOT use retired)	uring most of worki	ng			
7	ed within Hygiene. other tha		12th Ø		aims Cler	-		U.S.		
Maryland 21215-0036	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		<i>Maiden Suman</i> hns	ne)	
2	should be fil and Mental is marked aumatic eve		Wilbert Sheckler 19a. Informant's Name/Relationship (Type, Print)	405 14-95	ig Address (Street ai				State Zin C	toda)
Ma	2 should th and Mi 27 is mar traumati		Carol Lynn Nichols /Daughter	7221	- ·	ine Way,	Clarks			
ē,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b	. Place of Dispo	sition (Name of		Date	20c. Location	- City or To	wn, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) We		natory or other place ndel crem	· :	/2010	Ode:	nton,	MD
alti	mit. F partm porta y inju ce.		21. Signature of Funeral Service Licensee		. Name and Address		naldson	Funera	al Hom	e, P.A.
B	89 E 8 8			1103	313 Talbo		<u> </u>	rel, M	207	07
			23a. Part 1 Ener the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dying			est,		Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	Deep	TZ	Canci	26		- 0	Onset and Death
-	Medical Examiner		resulting in death) Due to (or as a conse	equence of):						'
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):					_	
	ted J Insit	Examiner	cause (Disease or iinjury						V/I	
	ate be executed ohysician and the burial-transit	Ë	that initiated events resulting in death) Last C. Due to (or as a conse	equence of):						
09	ate be ohysicia the bur	dical	d							
687	rtifica ing ph s as tl		IF FEMALE:				-			
9 X	eath certifica attending ph I for use as ti	ian/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of the past 12 months?	etal death 3 _	Ectopic pregnancy Other (specify)	/			ate of delive Ionth	ery Day Year
Box	the a	iysic	1 Yes 2 No 4 Pregnant at time to g Unknown	ordeath or	other (specify)					
P.O.	ires that the dea signed by the a Id be detached f	Completed by Physician/Mo	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
S,	uires t n sign lid be	q pe					1 □ Y	es 2 No	3 🗌 Prot	oably 4 🗌 Unknown
oro	w require s been si should I	plet					24a. Was a autop		. Were autop	osy findings available mpletion of cause of
3ec	The law cate has page 2	mo;			-		_ perfor	med?	death?	2 No
a	sician: The certificate I irector, pagi	Be	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec	k only one)	1		
Ξ	Physician: this certific ral director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2			4 ☐ Nursing Ho	me 5 Resid		her (Specify	Pospice
٥	ding Ph th. After th funeral	ate:	27. Manner of Death 28a. Date of injury (Month, Day, Year)	28b. Time of injury	work'	rat ? Yes 2 □ No	28d. Describe h	ow injury occu	rred	1
Sior	death death ctor: y the	Certificate:	Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, str		163 2 1140	28f. Location (S	treet and Num	ber or Rural	Route Number,
Division of Vital Records,	al or A safter I Dire d in b		4 Homicide determined building, etc. (Spec	cify)			City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Launeral Director: Attent this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my kni (Check Medical Examiner: On the basis of examina	owledge, death	occured at the time,	date and place, ar	d due to the cau	ise(s) and mar	ner as state	d.
	the Hy nin 24 the Fu	Mec	only one) 3 Certifying Nurse Practioner: To the best of	my knowledge,	death occurred at the	time, date and place	e, and due to the	cause(s) and	nanner as st	ated.
	North Connoc		29b. Signature and title of certifier NACHY: MACHY: 1	29c License	number	7-a	29d. Date sign	ed (Month, I	Day, Year)	
J				0-17	2 DO	0 311		711		
•			30. Name and address of person who completed cause of death (If	6701	W. Ch	oules !	Tret	,100	NOON	11112120
	Sta	te	31. Date filed (Month, Day, Year) ,32. Registrar's Sig	ingture 4	Nad.					
	Registr		MAY 2 U 2010	The state	A CONTRACTOR OF THE PARTY OF TH					

Timothy Francis Jenkins 10-03517 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ink Unk			1- For State	tate of Maryla	•	rtificate of		id Ment			201	0 15/6
Phys	icia		Registrar 1. Decedent's Name (First, Midd					-	2. Date of De		V	3. Time of Death
Medical Exa	amir	ner	Timothy Franc						Month May 6, 2		Year	1233 hrs
A. C.		ı,	4a. Facility Name (if not institution 7466 Rail Road Ave	on, give street and nur	mber)		4b. City, Town, o Hanover	or Location of	f Death		unty of Death Arundel	
Fune Direct			5. Social Security Number		7. Age (In yrs. I		If Under 1 Ye		Min.		Foreign	hplace (State or Wash D.C
Direct	-		218-76-6228 Usual Residence of Decedent	1 X M 2 F	4]	Yrs	i		11-26	-1968	Cou	intry)
, any			10a. State 10b. County		10c. City,	, Town or Locat	ion					10d. Inside City Limits
Maryland 28a-f show	once.	ğ		Arunde1	00	lenton						1 Yes 2 X No
e Mary	ied at	Director	10e. Street and Number	aa Harr			10f. Zip Code	2		10g. Citizen o		try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	e notif	!	2528 Piney Pa 11. Marital Status		edent Ever in U.	.S. 13. Wa	2111 s Decedent of H		n? (Specify Yes or N		SA Race - Americ	an Indian, Black,
death	must b	Funeral	1 Never Married 2 X M	1 Yes	2K No	If Y	es, specify Cuba	an, Mexican, I	Puerto Rican, etc.)		White, etc.	
s after	niner	۾	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates:			Yes 2 X N		ind of work done	Spec		
72 hour	I Exa	ompleted	Elementary/Secondary (0-12)				ost of working lif			16b, Kind (of Business/In	idustry
0036 vithin '	Medica	E C		4		Fleet	Manage				omotiv	e
21215-0036 and be filed within 7 Mental Hygiene. marked other than	t, the	မှု လ	17. Father's Name (First, Middle Joseph Jenkin						Name (First, Middle,	Maiden Surn	ame)	
212 ould be I Ment	ic even	B	19a. Informant's Name/Relations			19b. Mailing	Address (Stre		rma Smith per or Rural Route Nu	mber, City or	Town, State,	Zip Code)
MD id 2 sho lith and m 27 is	anmat	1	Karen Connolly		Wife				ay Odenton			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	ther tr	1	20a. Method of Disposition 1 Burial 2 K Cremation	n 3 Removal fro		Place of Dispos crematory or oth	ition (Name of co ner place)	emetery,	Date	20c. Locat	ion - City or T	own, State
Itim it. Pag urtment	y or 0	ŀ	4 Donation 5 Other S		W.		Cremat		5-14-2010	Oden	ton, M	aryland
Ba Perrr Depi		l	E. kelat	hai	M011	l Do	naldson	Funer	cal Home & Road Odent	Crema	tory, rvland	P.A. 21113
Physicia /M			23a. Part I. Enter the disease, or failure. List only one cause		used the death.	. Do not enter th	ne mode of dying	, such as car	rdiac or respiratory an	rest, shock, o	r heart	Approximate Interval Between Onset and
Examin		1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Due to (or as a c								Death
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		l je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a o	consequence of	f):						
Pa	nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of	f):						
execut			X UNPENDED	d AMENDED	07.00			2 5/2/	/10 mm			
760, cate be exe	the burial	Med.	IF FEMALE:	200, 1, 700, 0	atoonio oi progi	nancy	ME g90	3 5/24	1/10 TT	23d. Dat	e of delivery	
OX 6876 eath certificat eathending ph	use as	sician/Medical	23b. Was decedent pregnant in the past 12 months?	I I LIVE DII	th nt at time of de	ath _	al death 3 ner (Specify)	Ectopic p	oregnancy	Mont	h Da	y Year
Box ne death of the atten	ਲ	ᇍ		known 9 Unknov								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	deta	<u>a</u>	Part II. Other significant condit	tions contributing to	death but not re	esulting in the u	nderlying cause	given in Part				e cause of death? bly 4 Unknown
Vital Records, hysician: The law require this certificate has been si	pluod b	Completed						-	24a. Was			ppsy findings available
(eco The law	age 2 s	E O	100		·				autop perfo 1 ✓ Yes	rmed?	death?	mpletion of cause of
		Be -	25. Was case referred to medica examiner?				26.Place		theck only one)			
of Vit ng Physic After this	lag I	٥,	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Ing		ER/Outpatient 28b. Time of In		Other I		Residence		
	the fund		1 Natural 5 Pend	(Month, E	Day,Year)	12:29 p	1	Yes 2 X	subject a movi			front of
Division tal or Attendi	d in by	ertification:	3 X Suicide 6 Coul	d not be 28e. Place			t, factory, office I	building, etc.				Route Number, City
Ospital hours uneral	ly filled	ح ا	29a. Certifier	rmined (Specify)	train		and as she stimes of					
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct	completely			hysician: To the best of miner:On the basis of and manner sta	examination ar							
H × H	۵ :	¥ E	29b. Signature and title of certifie				29c. Licens				igned (Monti	h, Day, Year)
			10-MU	~			O.C.	M.É.		May 7, 2	:010	
			 Name and address of person Donna M. Vincenti, MI 				Penn Street	, Baltimor	e, MD 21201			
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signatur	re la la	arkel					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 14 2010 9:05 AM M Virginia Bryant Kimbell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Maryland Towson, If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🔀 F (Month, Day, Year) 11/20/1915 Director 214-18-9574 94 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland be notified at **Funeral Director** 1 Yes 2 No MD Baltimore Essex 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Savannah Road 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Forces Black, White, etc. or, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", matic event, the Medical Exa Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Proof-Reader</u> Printing Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ (Unknown) Bryant Clara Anna Albrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s Health tem 27 Gwen Chilcote 240 Victory Lane - Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 💢 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 05/22/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityE. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last ohysician and the bunal-transit ate has been signed by the attending physician page 2 should be detached for use as the bunal 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 2. No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No HOSPICE 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 20 who completed cause of death (Item 23a) (Type, Print) N CHARLES ST. SUITE 4105 BALTIMORE, M.D. 2120 DANIEUE DOBERMAN, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Physician/ Year Amber Flynn Konkus Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center 1 more . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. May 19 1918 Months Yrs PA Director 206-09-8945 91 Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🌠 No FL Collier Naples 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 6600 Beech Resort Dr. #1 34114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: white Specify: Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withi trment of Health and Mental Hygien rtant: If item 27 is marked other th njury or other traumatic event, the 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leland Charles Flynn Margaret Haxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Leland Konkus/son 305 Wyndham Cir., Owings Mills, MD 21117 Department of Health Important: If item 23 any injury or other to once. 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5/22710 cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Michael Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner VALVULAR HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Je. Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed FIBRILLATION ATRIAL and burial-tran Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 ₹F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death ed by the a g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? After this certificate 2 X No 1 Yes 1 ☐ Yes 2 🗷 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 20a Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital o within 24 hours af To the Funeral Di completed filled in

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29b. Signature and title of certifier

State Registrar

621 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

7 chla

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D41412

TOWSON.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,\bar{0}\,\,\bar{1}\,\,\bar{0}$ State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year M 28:15 M M HERTHA KUHN MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKING BAYVIEW MEDICAL CENTER N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 216-46-4828 1 □ M 2 😿 F 95 Yrs Director 14.191 DEC. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural" or from many or other trainment. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Q Yes 2 No N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 801 S. BOULDIN ST 21224 IISA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates WHITE Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES STEWART ETTA KIEFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IDA KUHN-DAUGHTER BOULDIN ST BALTIMORE MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF JESUS: 5/21/10 BALTIMORE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC. 21. Signature of Funeral Service Licensee too 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final 10 Hours Ph sician/ FAILURE RESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 DAY PNEUMONIA que tietly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the contact of the cont signed by the attending physician and defeached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MAY 16, 2010 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD M.D 4940 EASTERN AVENUE CHANG DAVID 31. Date filed (Month, Day, Year) State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 1240 mili mas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Universit Medical Center Mariland altimore of Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign 1 □ M 2 X F Months Hours Min (Month) Day North Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Son) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, mon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 119 2010 21. Sign ture of Funeral Service Licensee 22. Name and Address of Eacility 23a. Part Enter of e disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 KN 25. Was case referred to medical 26. Place of Death (Check only one) 1 K Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at

Physician/ Medical Examiner burial-transit certificate be

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ral", or items 23a or 28a-f show Examiner must be notified at

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and Mental Hygiene.
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permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine attending physician Physician/Medical the as asn Į be detached signed by þ Completed peen has certificate director, Be ပ္ 24 hours after death.

Funeral Director: After this the funeral Certificate:

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of Vital Physician:

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	28d. Describe how injury occurred
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28f. Location (Street and Number or Rural Route Number, City or Town, State)

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29a.	Certifier	1 \(\mathbb{N}\) Certifying Physician: To the best of my knowledge, death occur.	ed at the time, date and place, and due to the o	ause(s) and manner as stated.
	(Check	2 Medical Examiner: On the basis of examination and/or investigation	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
	only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b.	Signature an	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 X Natural

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 19 ay Physician/ 2010 2:52 PM Patrick Joseph Lockhart Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 9, Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Month, Day, Year)
Feb 5, 1923 New York Hours 1 ☑ M 2 □ F 87 070-12-9943 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County death with the Maryland notified at Director 1 🗌 Yes 2 🎇 No Westminster Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 9 ral", or items 23a or Examiner must be Funeral **USA** 21157 98 Timber Ridge Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1942 1 Never Married 2X Married 2 Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: If Yes, Give "natural", 1945 3 Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumeria. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Grocery Store Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Veronica Glenn John Henry Lockhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 370 Doral Court Westminster, Maryland 21158 Christine Krebs, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/20/10 Baltimore, Maryland Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore. Marvland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bv page 2 should be 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s Yes 2 🔽 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 X Other (Specify) Hospice 2. No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? ___1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending Investigation 6 Could not be Accident 2 Accider
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2050763 X OI 30. Name and address of person who completed cause of death from 23a) (Type, Print) 826 Washington Road Suite 120 Westminster, MD 21157 M.D. Ernesto Mendoza, 31. Date filed (Month, Day, Year) 32. Rec State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day Vear 10.50AM **Physician** A. JAMES LUDWIG 2010 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Nursing Home Irvington N/A

9. Birthplace (State or Foreign Country) Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 70 Director 220-36-2968 October 20, 1939 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Modical Enginesis in collised at once. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 XYes 2 □ No Director Maryland N/A Curtis Bay 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1414 Locust Street 21226 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 | No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Natural Resoures Police 12 4 Corporal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles W. Ludwig L. Lundry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Toni M. Ludwig 1414 Locust Street, Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grdns. May 25, 2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 237 East Patapsco Avenue, Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one house on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEO PLASM PAROTID **Physician** resulting in death) /Medical Due to (or as a consequence of): WKNOWN HEM (FAVURE Examiner ONGESTIVE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner WILLIAM HIYPENCENS , SW physician and s the burial-trans Due to (or as a consequence of) attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be dete Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 2/No 1 □ Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 29a, Certifie 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTEM ING 00056948 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2125) 200 ARM 5th 7 PLACE SUITE 3 1 KANSIMO A JANE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAMA

10-03408 James Ray Locklear

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 1577

		1- For State Registrar		Ce	rtificate of	Death		,,	F	Reg. No).		
Physici		Decedent's Name (First, Mid-	dle,Last)						Date of De Month	Day	Year		3. Time of Death
Medical Exam	iner	JAMES RAY LOCI						N	May 3, 20	010			1302 hrs
		4a. Facility Name (if not instituti Johns Hopkins Bayvi	-		ľ	b. City, Town, Baltimore		or Death		٦	c. County of	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y		er 24Hrs. 8	. Date of B	irth (MN	4/DD/YYYY)	g. Birth	place (State or Foreign
Director			1XM 2 F		• •	Months D	ays Hours	Min.				Cou	ntry)
-		Usual Residence of Decedent	IZX IVI Z	16	3 Yrs.	<u> </u>		1 1	AUG.	31,	1946		NC
any		10a. State 10b. County	,	10c. City	, Town or Locati	on							10d. Inside City Limits
À .π	'n	MD		BAT	TIMORE								1 X Yes 2 No
faryla 28a-f Lator	Director	10e. Street and Number			LIMONL	10f. Zip Code	;			10g. Ci	tizen of Wha	t Count	ry?
ith the Maryland 23a or 28a-f sho notified at once	Σį	512 N. KENWOOI) AVE.			21224				USA			
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral I	11. Marital Status	12. Was De	cedent Ever in U		Decedent of I			y Yes or N				an Indian, Black,
r deat or ite	핊	1 X Never Married 2 N	1 Yes	2 🔀 No					an, etc.)				
s afte rral", niner	ģ		vorced If Yes, Give Ye or Dates:			Yes 2 X 1				1401			. INDIAN
2 hour "natu Exar	Completed	 Decedent's Education (Spin Elementary/Secondary (0-12) 		1-4 or 5+)	16a, Decedent during mo	st of working I				166.	Kind of Busi	ness/Ind	dustry
336 thin 7: than than	ble	12TH	,	,	ROOFI	סיי					ROOFIN	JC.	
5-00; iled with Hygiene I other ti	Soi	17. Father's Name (First, Middle	e, Last)		1,0011	ш.	18.Mother	's Name (Fir	st, Middle,			10	
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than	Be	ALBERT LOCKLE	AR				ROSA	LOCK	LEAR				
ID 21 should and Me 7 is ma	ပ	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Str	reet and Num	ber or Rura	l Route Nu	mber, (City or Town,	State, 2	Zip Code)
e, MD I and 2 sho Health and item 27 is		WILLIAM JONES	NEPHEW	Loo	3504	FAIT	AVE.,						
L S L L	m	20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal f		Place of Disposi crematory or oth	tion (Name of o er place)	cemetery,	Da	ate	20c.	Location - C	ity or To	own, State
imC Page ment tant: or ot		4 Donation 5 Other S	Specify:	/	ARDE	INT		05/09	/2010	Н	ANOVEF	۲ , M	D
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Funeral Servi	en No.	11		ame and Addre		MEST					RL. HM.
Physician	-	23a. Part I. Enter the diseas	complications that	ar sed the death.	Do not enter th	2007-09 e mode of dvin	EASTE	IRN AV	E., B	ALT rest. sh	IMORE	MD	21231 Approximate Interval
/Medical		failure. List only one cause	e on each line.	5.0		.	3 ,		,		,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequence of								\dashv	2000.
		Sequentially list conditions,	b										
	Ē	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	f):								
.0 -	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of	f):							_	
an and transi			d										
ਜ਼ਿਸ਼ ਦੇ	/Medical	UNPENDED	AMENDED										
		IF FEMALE: 23b. Was decedent pregnant in t	he	outcome of pregr			B Ectopic			23	d. Date of de		V
Box 68' death certifi he attending d for use as	ciar	past 12 months?	I	nant at time of de	ath =	aldeath 3 er <i>(Specify)</i>	o	pregnancy			Month	Da	y Year
Boy death	Physician	1 Yes 2 No 9 Un	known g Unkn	own	J Out	Ci (() () ()							
P.O. Box that the death med by the atter detached for u		Part II. Other significant condi	tions contributing to	o death but not re	esulting in the un	derlying cause	e given in Pa	rt I.				_	e cause of death?
S, P.C nires that signed to be deta	od by								1Ye	s 2	/ No 3 _	Probab	oly 4 Unknown
cords law requi has been 2 should	Set								24a. Was autor				psy findings available npletion of cause of
Rec(The lar icate ha	Completed								perfo	rmed?		ath? Yes	2 No
Vital Reo ysician: The his certificate director, page	Be	25. Was case referred to medica				26.Pla	ce of Death (Check only	one)				
Vit		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸	ER/Outpatient	3 DOA	Other 4	Nursing Ho	me 5	Reside	ence 6	Other:	
ion of tending Pheath.	اڃَ	27. Manner of Death 1 Natural 5 Per	28a. Date	of Injury Day Year) 2010	28b. Time of Inj	· ·	jury at Work	Driv			ury occurred ote fixed o		collision
SiOr Vittence death ctor:	atic	Pen	stigation				Yes 2	No					
Division of Vital Records, P.O our after death. The law requires that to our after death. In the law requires that the all Director: After this certificate has been signed b filled in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed.	Certification:	dete	id not be	e of Injury - At ho		, factory, office	building, etc				and Number ay, Baltimo		Route Number, City
Ospita hours unera ly fille		29a. Certifier	(0000)/	Major Road		- d - t th - tim-	4-4 4 -1-						
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		hysician: To the bes miner:On the basis	of examination ar									
To with	Mec	29b. Signature and title of certific	and manner s er	tated.		29c. Licer	nse number			29d.	Date signed	(Month	, Day,Year)
	~~	114	X	AD		0.0	M.E.			May	y 4, 2010		
4	1	30. Name and address of person	who completed caus	se of death (Item	23a)								77 - 72 - 73 - 74
\mathcal{V}		Russell Alexander MD		ledical Exam	iner 111 i	Penn Stree	t, Baltimo	re, MD 2	1201				1
St	ate	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatur	parks	,			OCME		•		
Regist	gar.	MAI & U ZUI	V Million	- 1- /	/								

			1 - For State Registrar	State	of Marylar				lealth a Death	and M	lental Hy	giene Reg. No.	2010	15	772
			1. Decedent's Name (First, Middle,	Last)							2. Date of De		Year	3. Time of	Death
	Physici /Medic		_	Dav	id Lyda	Linar	d, Sı				May	14,		4:20	ΡM
	Examin		4a. Facility Name (If not institution, g	give street and nu	umber)		4b. City	Town, or	Location of	of Death		4c.	County of Dea	th	
r			4812 Wicomico					tsvi		0411 1			ince G		
	Funeral Director		5. Social Security Number 232-05-1078	. Sex 1 XM 2 ☐ F	7. Age (In yrs. 91	. last birthday) Yrs.	Months		If Under Hours	Min	8. Date of Bi (Month, D June 1	av. Year)	9. Bir Co Oh.	thplace (State o puntry) 10	r Foreign
	pu. N	1	Usual Residence of Decedent 10a. State 10b. County		100 0	ity, Town or Lo	antina.							10d. Inside Cit	to I besite
	laryla shov	5	,			_	ocation							1 X Yes	-
	the IV	Director	MD Prince	George	La	urel	101 7	p Code		_		10a Citi	zen of What Co		
	with be or													outility:	
	ns 23	Funeral	900 8th Street	12. Was Dec	edent Ever in U	JS 13	1	0707	isnanic Ori	igin? (Sne	cify Yes or No	U.S.	A . I4. Race - Ame	erican Indian	
0	fter d riten	필	1 ☐ Never Married 2 ☐ Married	Armed Fe	orces? 2 📉 No						ecify Yes or No Rican, etc.)	ĺ	Black, White	e, etc.	
<u> </u>	al",o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or D	ive Dates:		1 □Yes	2 X No	Specify:				Specify: Wh.	ite	
9200-91212	be filed within 72 hours after death with the Marylan Hygiene. id other than "natural", or items 23a or 28a-f show other than "strong learn" or items 23a or 28a-f show event, the Madeal Example of the strong learning at the matter of the strong learning at the matter of the strong learning at the matter of the strong learning at the strong learning at the strong learning at the strong learning l	Completed	15. Decedent's (Specify only highest of	Education)	16a. Dece	dent's Usu	al Occupa	ation during mos	t of working	27	16b. Kir	nd of Business	/Industry	
7	ithin ne.	du du	Elementary/Secondary (0-12)	College (life.	DO NOT i	se retired) -		ø				
7	led w lygiel her ti			1		Mech	anica	ıl En	ginee		/F: A4: 111		ospace		
yland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Midical Examination is all built like at	Be	17. Father's Name (First, Middle, La	St)							(First, Middle	, Maiden	Surname)		
Ë	hould d Me mark matic	မ	Ray Linard 19a. Informant's Name/Relationship	(Taran Dalan)		405-14-70		(0)		.e Cu		0"	T 0	7. 0. 1.	
Mar	d 2 s Ith an 17 is u	1 5	David L. Linar	, ,	/aon								Town, State, I		
ā,	1 an Hea tem 2		20a. Method of Disposition	<i>x</i> , <u>1</u> 1	/son	Place of Dispo				•	ate		cation - City or	d 20705 Town, State	
<u> </u>	ages ent of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State				i	1	0 10		-		. 7
baltimor	nit. F Partme ortan injur E.		21. Signature of Funeral Service Lice		FO	rt Lin	2 Name a	nd Addres	s of Facilit	hu	8, 10		itwood,	Marylar	na
ñ	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e once.		Lehl HI	1/1_	M007		Donal	.dson	Fune	eral	Home,		rland 2	0707-438	29
			23a. Part 1. Enter the disease, or co	mplications that	caused the dea	-							Turia 2	Approximate Interval Bety	e
	Physician	8 1	shock, or héart failure. List on Immediate Cause (Final disease or condition			+ b 20 1 ***	_							Onset and D	Death
1	/Medical		resulting in death)		lure to (or as a consec		9						-	months	3
	Examiner		Sequentially list conditions	b Dem	entia									2 year	rs
	it g	iner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):									
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	/										
, pQ,	icate be executed physician and the burial-transit	E E	rosulting in doutily adde	Due to	(or as a consec	quence or):									
200	Prystician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical		d											
XOO	w requires that the death certifications is been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregn	ancy							3d. Date of de	livory	
n	atter	ciar	in the past 12 months?	1 🔲 Live	birth 2 Feta	al death 3	☐ Ectopic ☐ Other (s		/				Month Month		/ear
5	the c by the	hysi	9 Unknown	9 □ Unki											
	s that pred to e deta	by PI	Part II. Other significant conditions	s contributing to d	leath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco u	se contribute to	the cause of d	eath?
ğ .	en sig	ed b									1 🗆	Yes 2	No 3□P	robably 4□ U	Jnknown
ecords,	aw re as be	Completed									24a. Was		24b. Were at	utopsy findings a	available
	ate ha	mo;									auto perfe	ormed? 2 X No	death?	completion of ca 2 □ No	ause of
VII a	Autending Prysician: The law are death. rector: After this certificate has by the funeral director, page 2 !	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only		12100	2 2 110	
5 6	nysik his o		1 ☐ Yes 2 🔀 No	Hospital: 1 🗆	Inpatient 2] ER/Outpatier	nt 3□D	OA Othe	er: 4 □ Nu	ırsing Hor	ne 5□Res	idence 6	Other (Spe		
= .	After 1	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day, Year)	28b. Time of Injury		28c. Injury Work			28d. Describe	how injury	occurred	resi	idenc
NISIOII :	tend Seath tor: / the f	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	bo		l ,	M		Yes 2□						
ξ.	or A after of Direction by	Certification: To	4 ☐ Homicide determine	Zoe, Place	e of Injury - At h ling, etc. <i>(Speci</i>	ify)	eet, factor	у, описе		2		(Street and wn, State)		ural Route Numi	ber,
	ours ours heral filled		29a. Certifier 1 Certifying	Physician: To the	e hest of my kno	owledge, deat	h occurred	at the tin	ne, date ar	nd place	and due to the	cause(s)	and manner a	s stated	
	e nos 124 h e Fur letely	ledical		aminer: On the b	pasis of examination	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurre	ed at the time	, date and	place, and due	e to the cause(s))
	lo tre nospital or attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	100			29	c. License	number			29d. Dat	e signed (Mont	h, Day, Year)	
			· //	1		ME	>	D2542	22			May	17, 201	LO	
			30. Name and address of person wh	o completed cau	se of death (Iter	m 23a) (Type,	Print)								
			Robert Maggin,		13952		ore A	ve. 1	Laure	1, Ma	aryland	207	07		
	Sta Registra		31. Date filed (Month, Day, Year)	32 F	Registrar's Signa	atore	WOL	2							
	11121111111		78 (3) B (C) B (64	177 STATE OF STATE	P	A Vand	1 10								

Amend Items State of Mary 2005, 057207201 Of Health and Mental Hygiene 0 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:25 P M May 12, Physician/ 2010 tnn a Medical 4a. Facility Name (if not institution, give street and number) Bultimore 4b. City, Town, or Location of Death **Examiner** Vy Hall 1300 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months Days Hours Min. (Month, Day, Yea 90 Director Texas 451-26-7980 192b Apr Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2-No MD Baltimore Essex 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o with Funeral 21221 United States 1106 Cedar Creek Road 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2 200 ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4-Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than within Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home <u> Home Maker</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ben Randals Iva Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delia Paddock /Daughter 1106 Cedar Creek Road Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Ferenation 3 Removal from State May 4 Donation 5 Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death EMBOLI SM Immediate Cause (Final Physician monar disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1 hrombosis venous Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) No. sate has been signed by the a page 2 should be detached 9 | Unknown Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate l 2 🗌 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 **N**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 \square No death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chukwuma Eso 1124 Mag Baltimore MD 2/221 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygienes Certificate of Death

Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Miller Day 3 2010 Physician/ Oliver 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County **Examiner** Randallstown Seasons Northwes HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 Country) larylan Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at with the Maryland Director 1 ¥ Yes 2 ☐ No laryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

MLSSENGER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. d other than * Parks Sausage Co. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last)

Oliver Milley . Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is merany injury or other. မ eato: 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kavenwood 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 21. Signature of Funera Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. **Amyotrophic lateral** Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of, the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Ferance
Pregnant at time of death in the past 12 months? Month Day Yes 2 No 1 Yes 2 9 Unknown 10 the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown **Hospital or Attending Physician:** The law requires that the 24 hours after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital Other: 1 ☐ Yes 2 🗹 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MSRappahse M.D D6057465 5/13/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 2835 Smith Ar. 5-235,

DHMH 17 Rev 7/2009

State Registrar N.J. Rajapakse, NID

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G906, 8/6/2010, WS/#8perFH, G907, 9/14/10, WS/State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ May 2010 2:45pMacAuley Medical 4a. Facilify Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>H</u>ill <u>Harford</u> Forest <u> Hart Heritage</u> Estates If Under 24 Hrs. 8. Date of BirtiSept . 6, 192 Birthplace (State or Foreign 5. Social Security Numb **220-05-8212** 218-03-8212 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** (Month, Pa) Davs Hours Min. 1 □ M 2 🕱 F Maryland Director 88 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County be filed within 72 hours after death with the Maryland 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 3324 Hazelwood Drive 21047 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 ₩ Widowed 4 Divorced Completed White Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Specialist Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Herbert Armiger Cora Lego 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. McCarthy/ Daughter 3324 Hazelwood Drive, Fallston, Maryland 21047 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 5/19/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final STAGE FIND Physician/ disease or condition resulting in death) JEDIN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the detached 9 Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has autopsy performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Yes 2 No death. Accident Investigation after death Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital within 24 hours a Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day

11 L GATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPAMIS

615

32. Regi trar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

35889

IMPHOID PO BUIDING MD 21014

		1- For State of Mary Registrar	rland / Department of Health and Me Certificate of Death	Reg. No.	6
/N	ysician ledical aminer	Phyllic Morrow	4b. City, Town, or Location of Death ADELPHI	2. Date of Death Month Day Year 4c. County of Death PRINCE GEORGES CO	> M
Fund Direct		1 M 27 F	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo Country) PA	reign
III (Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland nal Hygiene.	Executer nate by notified at	MD HOWARD COUNTY 10e. Street and Number 8398 AUTUMN RUST ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 10b. County 10c. Street and Number 11. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates:	c. City, Town or Location ELLICOTT CITY 10f. Zip Code 21043 Tin U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri	10d. Inside City Li 1 ☐ Yes 2 X 10g. Citizen of What Country? USA ify Yes or No- ican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE	
Id A I A I 3-0 filed within 72 ho I Hygiene. other then "natur	ent, the Marital	17. Father's Name (First, Middle, Last)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER 18. Mother's Name (OWN HOME (First, Middle, Maiden Sumame)	
Deficiency, Maryian permit, Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of	ther traumetic	LOUIS BOSCO 19a. Informant's Name/Relationship (Type, Print) GEORGE MORROW JR. 20a. Method of Disposition 1 Burial 2 Commation 3 Removal from State	19b. Mailing Address (Street and Number or Rural in 19b. Mailing Address (Street and Number or Rural in 19b. Place of Disposition (Name of cemetery, crematory or other place) QUANTICO NATIONAL CEMETERY	Route Number, City or Town, State, Zip Code) ELLICOTT CITY, MD 21043 te 20c. Location - City or Town, State 5-19-2010 TRIANGLE, VA	
Physic /Medi Exami	ian ical ner	23a. Part1. Enter the diabase, or comblications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a co	Uspiratoy Arrest. Insequence of): My ocerdial Infarct unsequence of):	Interval Betwee Onset and Deat	191 n
Physician: The law requires that the death certificate be executed rthis certificate has been signed by the attending physician and	Physician/Medical Examin	d. Hyper	regnancy Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year	
The law requires that to the has been signed by	page 2 should be detac	Part II. Other significant conditions continuously to dealth but he	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death 1	nown
ng e	ne tuneral director, p	25. Was case referred to medical examiner? 1	28b. Time of 28c. Injury at 28		
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After	pletely tilled in by the tuneral edical Certification:		y knowledge, death occurred at the time, date and place, an amination and/or investigation, in my opinion, death occurred	af. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated, d at the time, date and place, and due to the cause(s)	
To th Within	Comp	29b. Signalure and title of certifier	29c. License number 47867	29d. Date signed (Month, Day, Year) 5/20/10 Kulle MD. 20852.	
/5 V	State gistrar		n (Item 23a) (Type, Print) Notolph Pd # 216, Rocci Signature	xulle MD. 20852.	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MIROSLAWA MOCK Month MAY 18 2010 11:35AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death OAK CREST CARE CENTER BALTIMORE COUNTY BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ☐ M 2XXF Days Austria 217~58~6763 Director 89 June Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director Maryland Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10121 Ropemaker Drive 21042 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes XX No 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 VTS College (1-4 or 5+) Homemaker Homemaking~Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Joseph Stecyk Ilse Mock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven S. Mock (Son) 10121 Ropemaker Dr. Ellicott City, Md. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 ☐ Burial 2 🖄 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INc. 5~19~2010 Baltimore, Md. 21. Signature of Fundral Sourice Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I amediate Cause (Final Physician Alzhermers Isease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 21 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed' death? certificate 2 No ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၀ 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes Director: A Investigation 2 🗆 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18/2010 2171944 CRUP MSW 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blvd. Parkville, MO 21234 CRNP MSU

State

Registrar

Misslawa

32. Registrar's Signature

Contray Mercha	ant	1- For State Registrar	tate of Maryla		artment of ertificate of		nd Menta	l Hygiene	20	101	577		
Physic Medical Exam		1. Decedent's Name (First, Mid	Reg. No. Death Day Ye 2010	eath 3. Time of Death									
		4a. Facility Name (if not institut Maryland General Ho		Death	4c. County	of Death							
Funeral Director		5. Social Security Number 214-96-4181	6. Sex	7. Age (In yrs. 29	last birthday) Yrs.	If Under 1 Your Months Da	ear If Under 2 ays Hours	4Hrs. 8. Date of Min. 12	Birth (MM/DD/YYY	9. Birthplace (St Country)	ate or Foreig		
w any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Locatio	n				10d. Insid	le City Limits		
Maryland r 28a-f shor	Director	MD N 10e, Street and Number	IA		Baltim	Ore 10f. Zip Code			10g. Citizen of W		es 2 No		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland etailth and Martal Hygiene, tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	by Funeral Di	3 Widowed 4 Di	Married 12. Was Dec Armed Fo 1 Yes vorced If Yes, Give Yea	2 X No	If Yes	Decedent of H	an, Mexican, Pu lo <i>specify:</i>	(Specify Yes or verto Rican, etc.)	No- 14. Race Whit Specify:	Black	, Black,		
5-0036 ed within 72 hour tygiene. other than "natu	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12 10th grade				t of working li	fe. DO NOT use	d of work done e retired)		usiness/Industry			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Cor	17. Father's Name (First, Middle Isaac Merch	ant		Disabled Disabled 18.Mother's Name (First, Middle, Maiden Surname) Margaret Woods								
e, MD 2' I and 2 should Health and M item 27 is mi	J	19a. Informant's Name/Relation Lakeisha Wo 20a. Method of Disposition			26 Gr	enbur	g Ct.	Balti	more, M	n, State, Zip Code) d 21207			
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		1 Burial 2 Cremation Donation 5 Other S	pecify:	om State	Place of Disposition crematory or othe Mt. Cal	mel	5,	Date /24/201		City or Town, State			
	- (21 Signature of Funeral Service 21 Part I. Enter the disease, o	- Thom	1	430	00 Wab	H West Dash Av	ve, Bal	timore,	Md 212			
Physician /Medical Examiner		23a. Part I. Enter the disease, o ailure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. e a. Comp1	ication	s of rem				rrest, shock, or he	Between	nate Interval n Onset and Death		
	iner	Sequentially list conditions, b											
0, e be executed ysician and burial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):								
68760, certificate be ex nding physician se as the burial.	/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	utcome of pregi	nancy			<u> </u>	7/29./10 23d. Date of				
	Physician/M	past 12 months?	I L LIVE DI	ant at time of de	ath =	death 3 (Specify)	Ectopic pre	gnancy	Month	Day	Year		
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternompietely filled in by the funeral director, page 2 should be detached for use	Completed	25. Was case referred to medica						perl 1 ✓ Yes	opsy p orm <u>ed</u> ? d	Vere autopsy finding nor to completion of eath? Yes 2			
Vital hysician: this certif	o Be	examiner?	Unneitale	patient 2 🗸	ER/Outpatient 3		e of Death (Che Other 4 Nu	rsing Home 5	Residence 6	Other:			
ion of ttending Pt leath. tor: After t the funeral	ation: T	27. Manner of Death 1 Natural 5 Pend	$1 \log 8/6/2$	Day,Year)	28b. Time of Inju unk		ury at Work? Yes 2 X No		28d. Describe how injury occurred subject was assaulted				
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification	Date imore; in									umber, City		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	one) 2 Medical Exa	nysician: To the best miner:On the basis of and manner sta	examination ar	e, death occurred	, in my opinior	n, death occurre	and due to the cau ed at the time, date	and place, and du	ue to the cause(s)			
		29b Signature and title of certific	to le	A R	nest	29c. Licens O.C.			29d. Date signe May 17, 201	d <i>(Month, Day</i> , Yea	ir)		
q		30. Name and address of person Victor Weedn MD JD	Assistant Med			ın Street, E	Baltimore, M	D 21201			· · ·		
St Regist	ate	31. Date Med (Mon2, Pay 201	32. Reg	istrar's Signatur	marker								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20a-b, per Fh G903 5/27/10 TT

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Physician/ 2:10 AM MAY 17 MILBURN HENRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7221 DUNGLEN CT. DUNDALK BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-56-0088 Days 1**★** M 2 □ F Months Hours Min. 60 10-29-1949 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD BALTIMORE DUNDALK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7221 DUNGLEN CT. 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSES ASSISTANCE HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ CLARENCE MILBURN VERDELLA WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 DUNGLEN CT., BALTO., MD 21222 ROCHELLE WILKINS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Center 20a. Method of Disposition 20c. Location - City or Town, State 5/22/2010 TE Burial 2 X Cremation 3 - Removal from State 5/25/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Signature of Euneral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dhysician/ PROSTATE CANCER disease or condition resulting in death) METASTATIC YEARS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transil the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa RES-000 05-18-2010

DHMH 17 Rev 7/2009

State Registrar EASTERN AVENUE BALTIMORE

nd address of person who completed cause of death (Item 23a) (Type, Print)

CHRONISTER

USTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 2016 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner 4c. County of Death has Ala ecurity Number If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Funeral age (In yrs. last birthday) Birthplace (State or Foreign Country) nth, Day, Year) 7 - 194<u>6</u> 213-52-7697 1 🛣 M 2 🗆 F 63 Months Days Hours Min Director Yrs. MD. Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HARFORD MD. **JOPPA** 1 🗆 Yes 2 🄀 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21185 items 23a 125 RAVENSWOOD CT. UNITED STATES within 72 hours after death Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE "natural", 3 Divorced 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) DESIGN BUILDERS COMPANY CONTRACTING and Mental Hygivis is marked other Be other traumatic event, filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental ၉ HOWARD B. MAYS, SR. BEATRICE HODDINOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau JOYCE ANNE MAYS/WIFE 125 RAVENSWOOD CT. JOPPA, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
JESSUPS UMC CEMETERY 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5/22/2010 SPARKS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) permit. te of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the tipease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a ld be detached for Unknown g 🔲 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 Tes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 7 1 Inpatient 2 KER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural injury 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of appringing and/or inventionally inventional to the cause of appringing and/or inventional to the cause of appringing and/or inventional to the cause of appringing and/or inventional to the cause of apprincipal to th 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Marse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number Name and address of person who completed cause of death (Item 23a) (Type 500

Registrar

31. Date filed (Month, Day, Year)

10-03491 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dannie Moy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 30, 2010 1507 hrs Medical Examiner Dannie Moy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or WITH) **Funeral** Foreign Wash. DC Months Days Hours Min Aug 18, 1964 Director 45 578-94-9320 1 X M 2 F Usual Residence of Decedent iny 10c. City, Town or Location 10d. Inside City Limits 10a State or items 23a or 28a-f show must be notified at once. MT Prince Georges Riverdale 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 4409 E. West Highway USA 12. Was Decedent Ever in U.S. Armed Forces?UNK Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Yes If Yes, Give Year Yes 2 X No specify. 3 Widowed 4 Divorced Specify: white <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done unit 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unit 10 unk disabled none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) this Be Jimmi Jean Ramsch Robert Edward Moy 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9614 Meadow Lark Ave. Upper Mariboro, Md. 20748
111 Fenn Street; Baltimore, Maryland 21261 19a. Informant's Name/Relationship (Type, Print) O.C.M.E.Nancy Moy/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. Signature of Funera Service Licensee 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and Medical Death Complications of Cervical Spinal Cord Injury Immediate Course (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Records, P.O. Box 68760, The law requires that the death certificate be executed đ Physician/Medical 6a-19b per fh , 23a,27,28a-f per me g906 X AMENDED attending physician or use as the burial X UNPENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed?

certificate of Vital After this

page 2 should be fo the Hospital or Attending Physician: director To the Hospina, within 24 hours after death.

To the Funeral Director: A Division

Completed 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Pending 1 Yes 2 No subject was beaten 10-17-1987 10:45 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 5505 Belva Pl. Lanham, Md. determined (Specify)

bar 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

May 6, 2010

29b. Signature and title of certifier 29c. License number O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month 13ay 2010 5:05 Рм William Roberto Mackell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Queen Annes Annapolis 162 Brownswood Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-2-1959 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days MARY LAND 214-78-0352 50 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 √Yes 2 □ No MD. QUEEN ANNES ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 162 BROWNSWOOD RD

12. Was Decedent Ever in U.S. Armed Forces? 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: Specify: BLACK 1 ☐ Yes 2 🛣 No Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COOK FOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN MARY E. DOWNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MACKELL (WIFE) CLIFTON AVE. BALTIMORE. WENDY 4830 MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dig position 1 Rurial 2 XCres 3 Removal from State 5 Other (Specify) 4 □ Donatio METRO CREMATORY 5-20-2010 BALTIMORE, MARYLAND 21. Sig a ure D. HIBNER 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final diseas or condition resulting in death) CARDIOMYOPATHY Due to (or as a consequence of): HYPERTENSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? PULMONARY DISEASE OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show

Hygiene.

marked other

1 and 2 should be fii Health and Mental F tem 27 Is marked otl

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau

72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine

Completed

Be (

Certification: To

Medical

and burial-trar Physician/Medical the attending physics as the the à has After

requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending death.

hin 24 hours after death the Funeral Director: filled in by the

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

							autopsy performed?	Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2♣No				
25. Was case referre examiner?	d to medical		26. Place of Death (Check only one)									
1 ☐ Yes 2 N	lo	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	Home 5 Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 ★Natural 2 ☐ Accident	5 Pending investigation	3	Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurr	red				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At he building, etc. (Specif	ome, farm, stree	t, fact	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					

(Check only one)	2 Medical

ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

mentenstant

D54574

29d. Date signed (Month, Day, Year) 05, 17, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK KIM, MD

GLENBURNIE MD 21061 1412 N. CRAIN HWY 6A

31. Date filed (Month, Day, Year) State Registrar

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Mary	land / De				and M	-	giene Reg. No	001	0	15703	
	Registrar 1. Decedent's Name (First, Middle, Last)						erunca	rtificate of Death					· <u> </u>	U	3. Time of Death	
	Physician/ Medical ANGIOLINA MASCIANTONIO										Month May	Day 11			12:13 p M	
	Examin		4a. Facility Name (if not institution,	give street and nur	nber)		4b. City	, Town, or	Location of	of Death			County of D		L12.13 p	
1			Gilchrist Cente	r				son				Ва	ltimo	re		
	Funeral Director		5. Social Security Number 211-32-6639	6. Sex 1 ☐ M 2 🙀 F	7. Age (In)	vrs. last birthda 83 Yrs) If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Sept . I 2	th y, Year)	9.	Birthp Co <i>u</i> n <i>t</i>	lace (State or Foreign ^{ry)} Italy	
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9	or its	by F	1 ☐ Never Married 2 ☐ Marr		2 🔀 No		If Yes, spe	cify Cuba	n, Mexican	n, Puerto	Rican, etc.)		Black, W	hite, e	tc.	
903	urs af ural", al Exa	ted	3 🙀 Widowed 4 🗌 Divorced	If Yes, Gi			1	2.₺ No	Specify:				Specify:	Whi	te	
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<u>ylar</u>	ld be Menta arkec atic e	욘	Silvestro DiS	ebastian	0				Giud	litta	D'Oraz	zio				
Maryland	2 should be filed within 72 hours after death with the Maryland than demtall thygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	- 3	19a. Informant's Name/Relationsh			T	_				l Route Numbe			Zip C	ode)	
e,	and 2 Healti tem 2 ther 1		Armando Mascian 20a. Method of Disposition	itonio/So		0b. Place of Dis					ulton,		ocation - City	or To	un Stata	
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State	cemetery, c	rematory or	other plac	e)	May 2010			consvi			
≣ E	mit. P partm portar / injur		21. Signature of Funeral Service Li			1			s of Facilit		aldson	Fune	eral H	ome	, P.A.	
ñ	a m Del		▶ J. KenSlile		M(01053					Laurel					
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that nly one cause on e	caused the ach line.	death. Do not e	nter the mo	de of dying	g, such as	cardiac c	r respiratory ar	rest,		Ţ	Approximate Interval Between	
- [Physician/ Medical	0 1												Onset and Death		
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9	certificate be executed nding physician and use as the burial-transit	edical		d				· · · · ·						\pm		
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Box	death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		gnant at time			Ectopic pregnancy Other (specify)					Month Day Year			
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ď.	v requires that the death certific been signed by the attending should be detached for use as	by	Fait II. Other significant conditio	ns contributing to t	Death Dut no	t resulting in th	e undenying	J cause giv	enmran	1.					e cause of death? abiy 4 nknown	
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Vital Records,	sician: The law requires that the s certificate has been signed by th lirector, page 2 should be detach	Completed			1.00						auto perfo	psy ormęd?	prior deatl	to con	npletion of cause of	
<u>a</u>	ian: Ti rtifical ztor, pa	Be C	25. Was case referred to medical examiner?		-61-250-0			1 Yes 2 No 1 Yes 2 No							Z LI NO	
¥	hysici his ce il direc	10	1 Yes 2 No			2 🗆 ER/Outpa		OOA Othe	er: 4 🗆 Nu	ursing Ho	me 5 Resi	dence 6	Other (S)	oecify)	HOSPICE	
Division of	Jing P h. After t funera	Certificate:	27. Manner of Death 1 ► Natural 5 □ Pending	9	e of injury oth, Day, Yea	28b. Time injur	/	28c. Injury work	?	. 1	28d. Describe h	now injun	occurred			
SIO	Attend r deat ctor; by the	rtiti	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determi	not be	e of Injury - /	At home, farm,	M street, facto		Yes 2 🗆	_	28f. Location (Street and Number or Rural Route Number,					
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the l	best of my k	nowledge, dea	h occured a	at the time,	date and	place, an	d due to the ca	use(s) an	d manner as	stated	d. se(s) and manner stated.	
	the lathin 2 the l	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner	To the best	of my knowledg	e, death occ	urred at the	time, date	and plac	e, and due to th	ne cause(s	and manner	as sta	ited.	
	⊼.≱ 5 8		J Constitution of Continent	5 201)	28	DIA	1390	_			te signed (Mo		-	
			30. Name and address of person v	who completed cau	se of death	(Item 23a) (Type	e, Print)	ow!	-10							
			DANIEUE DOBE	RMAN, MU	670	OI NEHI	PRIFE	STI	SUI	TE 4	105 B	ACT	more	, A	10 21204	
	Stat Registra		31. Date filed (Month, Day, Year)		Registrar's S	ignature	has	11							10 21204	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BETTIE JANE 4 NOONAN 02:34 AM MAY 14 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW NEDICAL CENTER N/A BACTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 □ M 2 🙀 F Months Days Hours Director 300-20-0651 Ohio 17,1922 Jan. Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, Dr. Madcal Evanians and the resistance of the management of the management of the second of Director Dunda1k 1 TYes 2 No MD **Baltimore** the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7663 Old Battle Grove Road United States Funeral 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: 2 Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 12 Years Assembly Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eda Mae Horton William Hildreth, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s' (Health a Hem 27 ir 101 North Main Street Shrewsbury, PA Mr. Robert J. Noonan, Jr. (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 permit. Pages
Department of
Important: If It
any injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/20/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or compleations that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FHIWRE 6 HOURS /Medical Due to (or as a consequence of): Examiner PNEUMONIA 1 DAY Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 🗌 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation To the rusping after death.

To the Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MAY 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

DAVID CHANG

31. Date filed (Month, Day, Year,

AVENUE

BALTIMORE

4940 EASTERN

rar's Signature

32. Regi

21224

MD

15785

		•	For State Of Wild Registrar	Cer	tificate of D			Reg. No.					
	Physicia		Decedent's Name (First, Middle, Last) Jacqueline June Noyes				2. Date of De Month May	ath 1 Day	20 f d	3. Time of Death 2:14 A м			
upon.	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Aberdeer			4c. County of Death Harford					
	Funeral			e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthpl	ace (State or Foreign			
	Director		Usual Residence of Decedent										
	laryland 3a-f sho iified at	Director	10a. State 10b. County Maryland Harford	10c. City, Town or Loc Aberdeen	cation				10d. Inside City Limit				
	ith the M 3a or 28 it be not		10e. Street and Number 217 Edmund St		10f. Zip Code 21001			10g. Citizen of What Country?					
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 Y 1f Yes, Give Year or Dates.	No	Vas Decedent of His i Yes, specify Cuban ☐ Yes 2 🛛 No		ecify Yes or No- Rican, etc.)		Race - America Black, White, e cify. White	tc.			
15-0	72 hour In "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of work	king	16b. Kind o	of Business Ind	ustry			
1212	d within lygiene. ther thant, the I	0	Elementary/Seconday (0-12) College (1-4 or 5	+)	ne Operato		Manufacturing			g			
/land	d be file Jental H arked of	To B	17. Father's Name (First, Middle, Last) John David Noyes			18. Mother's Nam Unk	ne (First, Middle,	Maiden Surn	ame)				
, Maryland 21215-0036	nd 2 should saith and h n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Diana Farmer / daughter	al Route Numbe	nber, City or Town, State, Zip Code)								
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos	sition (Name of natory or other place	9 5/15	Date /2010	West (Penns	on - City or Toy Chester ylvania	vn, State			
Balt	permit. Depart Import any inj	20	21. Signatur Jonerat Lannsee	22 To	Name and Address arring-Ca 33 S. Par	of Facility rgo Fune ke St. A	ral Home berdeen	P.A MD 2	1 001	J.			
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a		rest,		Approximate Interval Between Onset and Death						
3760	ficate be executed g physician and as the burlal-transit	by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (one a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	ıysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome to the Birth of the Pregnant at the	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of delivery Month Day Year					
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Division of Vital Records,	sician: The law requires that the descentificate has been signed by the rector, page 2 should be detached	Completed					24a. Was	an 24	24b. Were autopsy findings available prior to completion of cause of				
tal R	sian: The strifficate ctor, pa		25. Was case referred to medical examiner?			ce of Death (Chec	1 ☐ Yes k only one)	2 XNo	1 Yes 2	P □ No			
of Vit	Physic ar this ce aral dire	မ	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur		other	4 ☐ Nursing He	ome 5X Resid						
ion	tending death. tor: Afte the fun	Certificate:	1 X Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			∕es 2 □ No		e how injury occurred					
Divis	tal or At		4 Homicide determined 28e. Place of Injubuliding, etc	et, factory, office			n (Street and Number or Rural Route Number, Town, State)						
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 XCertifying Physician: To the best of a 2 Medical Examiner: On the basis of examiner on the basis of examiner on the basis of examiner. To the leads of the control of the basis of examiner on the basis of examiner.	camination and/or investi	igation, in my opinion	n, death occurred a	t the time, date a	and place, and	due to the caus	se(s) and manner stated.			
	To the To the comp		29b. Signature and title of certifier		29c. License	number		29d. Date sig	ned (Month, Da	ay, Year)			
	•		30. Name and address of person who completed cause of de	eath (Rem 23a) (Type, P	rint)	17	11000	2 17 4	G	Md 2: 50			
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registra		. unun	Ave,	ITPAUK A	rve	Hee	1 1C, 81078			
	Stat	e.	GEORGE L. HENRY MO		nint) Do	Ave,	HAUR	e De l	Fince	Md. 2107			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 Physician/ MFYFR OXMAN 4:40 AM MA 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE Sex 1 M M 2 □ F Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Hours 1172171923 Director 217-20-3474 86 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No MD BALTIMORE BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a 3312 LEE COURT 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterredical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the OWNER REYMAN DRUG COMPANY other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked of jury or other traumatic even MAX OXMAN MARY HANDELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCIE LURMAN / DAUGHTER 3210 NORTHBROOK ROAD, BALTIMORE, MD 21208 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI TFILOH CEM. 4 Donation 5 Other (Specify) 05/14/2010 WOODLAWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900_REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ArresT Ph_sician/ RESPIRATION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Assivation nows Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of) DELEVUUM the burial-transi The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation 2 No 3 Probably 4 Unknown Bowel obstruction - Lesion undefined Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy DRIMENTIA - muld within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🔲 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ð 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 🖳 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D30377 1000 へかっ 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Ave 21215 6 503 PAPUL HEIGHTS WW) RUBERT M. COOPER

DHMH 17 Rev 7/2009

State Registrar 32 Registrar's Signatu

Registrar

68760

Box

Division of Vital Records,

	-	For State Registrar	State o	of Marylar			nt of Health e of Death			giene Reg. No.	7 11 11	57	88
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	or	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation				20,1	703 1202	10d. Inside City Lir	mits
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ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Deceder (Specify only highe Elementary/Seconday (0-12) 12 Years) -4 or 5+)	(Give k	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook Restaurant								
and 2	To Be	17. Father's Name (First, Middle, L Charles H.				000	18. Mo		ne (First, Middle,		Surname)	-	
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Baltimore, N permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (S		State	Place of Disposemetery, crem	natory or o	me of other place) emetery	i	Date 21/2010		ocation - City or	Town, State , Marylar	nd
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Sta Registr		31. Date filed (Month, Day, Year)	07 474 - FT 4 32. F	Registrar's Signa	4 19	~ BH	310-1-4						

DHMH 17 Rev 7/2009

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	10	-	30. Name and address of person who completed caus			Print)					2010
	12			000	FRANI	LLIN S.	quare c	0R 130	elto n	nd a	21237
	Sta Registra			egistrar's Sign							
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John	Reamy	

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hn Reamy	State of Maryland / Departn	nent of Health and Mental H cate of Death	Comme and I	0 1579			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	odic of Bodin	Reg. No. 2. Date of Death	3. Time of Death			
ledical Examine	John Reamy		Month Day Year May 1, 2010	0200 hrs			
	Facility Name (if not institution, give street and number) Southern Maryland Hospital Center	4b. City, Town, or Location of Death Clinton	4c. County of Death Prince George				
Funeral	5. Social Security Number unk 6. Sex 7. Age (In yrs. last b			thplace (State or			
Director	1 [®] M 2□F 73	Yrs. Months Days Hours Min.		untry)			
,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits			
ow any	, , , , , , , , , , , , , , , , , , , ,	nton		1 Yes 2 No			
Maryland 28a-f show 1 at once. ector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cour	ntry?			
the Maryland or 28a-f sh tiffed atonce	6210 Willow Way	20735	USA				
er death with to or items 23s	11. Marital Status UNK 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		can Indian, Black,			
or ite	Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		• .			
rs after rral", miner	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15 Decedent's Education (Specify only highest grade completed) 16a	Specify: Wh	ite				
5-0036 ed within 72 hour lygiene. other than "natt he-Medical Exar	red)	ATTK.					
036 ithin 7 ane. r than fedica	unk unk						
21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	17. Father's Name (First, Middle, Last) unk	18.Mother's Name	(First, Middle, Maiden Surname) unk				
2121 ould be fi d Mental I s marked tic event,	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or F	Rural Route Number City or Town State	Zin Code)			
MD 2 shou alth and N 2 si ra aumatic		lll Penn Street; Balt					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner, must be notified at once To Be Completed by Funeral Director		e of Disposition (Name of cemetery, atory or other place)	Date 20c. Location - City or	Town, State			
MOI Pages ent of int: Il	1 Burial 2 Cremation 3 Removal from State cremi 4 Donation 5 X Other Specify: in State						
Baltimore, permit. Pages 1 an Department of Hea Important: If itel	21. Signature of Fun and Service Licensee	22. Name and Address of Facility State Anatomy Boar	d: 655 W. Baltimor	e Street			
	23a. Part I, Enter the disease, or complications that caused the death. Do	Baltimore, Maryian	a 21201	Approximate Interval			
Physician	failure. List only one cause on each line.	vascular surgery for		Between Onset and Death			
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): V		· For-Frederic	-			
_	Sequentially list conditions, b.						
nine in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c						
cuted Ind Itransit II Examiner	events resulting in death) Last Due to (or as a consequence of):						
0, e be executi ysician and burial - trai	X UNPENDED AMENDED 27 28 - 5	000 10 0 10 1					
60, ate be ex hysician ie burial	IF FEMALE: 23c. If yes, outcome or pregnance	per ME g908 10.8.10	1"1" 23d. Date of delivery	,			
cath certificate eath certificate attending phy for use as the brisical signal was a state to be second to be	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregna	ncy Month D	Day Year			
Box e death c the atten ed for us	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)					
C # 35 0	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to				
S, P.C puires that an signed ald be deta			1 Yes 2 No 3 Prob	topsy findings available			
Records, The law requires ficate has been signing 2 should be Completed				ompletion of cause of			
tal Rection: Te certificate ector, page	Dr. Warren of and American	26.Place of Death (Check of	1 Yes 2 No 1 Ye	es 2 No			
fital sician is certi lirecto	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/	louber	g Home 5 Residence 6 Other				
of Ving Physi ing Physi After this Cuneral di	Tes 2 No	. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred				
ion itendii leath. for: /	Natural 5 Pending 4/29/10 un	ık 1 Yes 2 No	unk				
Division of Vital Records, spital or Attending Physician: Te law requirements after death. Internal Director: After this certificate has been so filled in by the funeral director, page 2 should Certification: To Be Completed	3 Suicide 6 Could not be determined (Specify) Hospital	farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)Southern Hospital Clinton,				
Lospita Hours Unera	29a. Certifier 1 Certifician Physicians. To the heat of my knowledge of						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	one) 2 ✓ Medical Examiner: On the basis of my knowledge, under the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred a	t the time, date and place, and due to the	e cause(s)			
E S H S E	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)			
	Theodore M. Korg JA, w.	O.C.M.E. OCI	ME May 6, 2010				
	30. Name and address of person who complete cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exar		e. MD 21201				
State	100 Paristal Co.		.,				
Otate	WILV DO DOHO A	A backer					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Hildegard Theresia Ramsey 2010 3:30 A M 18 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford 210 Angus Dr. Aberdeen 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F Months Days 12/04/1926 83 Director 215-82-6622 Germany Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Harford Aberdeen Maryland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA 210 Angus Dr. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married ş Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.White If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Bulliq Anna Scheel and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buel P. Ramsey 210 Angus Dr, Aberdeen, MD 21001 permit. Page 1 and 2 Department of Healt Important: If item 2? any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State West Chester. 5/20/2010 4 Donation 6 Other (Specify) R.A. Ferris & Co. Pennsylvania Funeral vervice Li 21. Signatur 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death VARIAN CANCER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Naturai 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: A Investigation 6 Could not be in by the Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled Medical To the Hosp within 24 hou To the Funer completed fil 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 18, 2010 PHYSZ JAN D0058475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATHOOD ROAD, BELATR, MO 21014 PHZIZPNARTPUNZ 602 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Registrar's Signatu

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Amend Items 9,10b,c,17,18,29d per sa/dr.,g06/07/2010dib

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 24a,25,26,27,29a per dr., 2903.05/20/2010dhb

Reg. No. 2 | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 16:49 P M May 6 2010 Mary F. Scott /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign Country) Florida Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Min. Months Days 1 □ M 2 □ F Feb 10, 1927 83 249-34**-**1015 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location tha State 10b. County Washington show r items 23a or 28a-f shov iner must be notified at Boonsboro 1 ☐Yes 2X No MD Caroline Greensboro Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7606 Fairplay Rd. 21713 USA Funeral death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumant. 11. Marital Status 1 ∐Yes 2½∏No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) customer service publishing company 18 Mother's Name (First, Middle, Maiden Surname Willie Mae Ferqueron Willie May Serqueron 17. Father's Name (First, Middle, Last) unk Be Martin Henderson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 5239 Crown St; Bethesda, Maryland 20816 Cheryl Scott Williams/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 21. Signature of Funeral Survi Baltimore, Maryland 21201 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedine Cause (Final Physician acute respiratory distress disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner septic shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine aspiration pneumonia physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760 law requires that the death certificate be Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown been signed by should be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş acute renal failure 1 Yes 2 No 3 Probably 4 Unknown Completed complete heart block 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed?

1 □ Yes 2 No 1 ☐Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**X** No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cert ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Me al[Examilher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month Pay 2010) 29c. License number 29b. Signature and title of ce 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 3 Dr. Piotr Wyrwinski 7600 Carroll Avenue; Takoma Park, Maryland 20912 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

me son start

2,24a,25,

10-03787 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Angelo Luis Serrano, Jr 2010 15794 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ May 17, 2010 1243 hrs **Medical Examiner** Serrano, Jr. Angelo Luis 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard Ellicott City 10735 Homewood Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreign Country Illinois Days Min Months Hours)4/17/1965 Director 1 M 2 F 45 59-49-6429 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No or 28a-f show Ellicott is marked other than "natural", or items 23a or 28a-f shov atic event, the Medical Examiner must be notified at once. Howard Maryland within 72 hours after death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA ā Joey Drive 9603 Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No White 4 X Divorced If Yes, Give Year 1 X Yes 2 No specify: Specify: <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 5-0036 Limore, MD 21215-0036

Pages 1 and 2 should be filed within 7 ment of Health and Mental Bygiene, trant: If item 27 is naved other than or other traumatic event, the Medicas ARC of Maryland Life Skills Assistant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Angelo Luis Serrano, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ 5915 Montgomery Street, Gwynn Oak, Maryland 21207 Yahir C. Rangel/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, 1 Burial 2 Cremation 3 Removal from State |Baltimore, Maryland 5/19/2010 Department (Important: injury or otl Metro Crematory, Inc. 4 Donation 5 Other Specify 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland, 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Madical Death a. Carbon monoxide Toxicity Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and the burial - transi The law requires that the death certificate be executed Sa UNPENDED AMENDED Physician/Medi Box 68760 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending p 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 V No 3 Probably 4 Unknown Ş σ. Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has b death? performed Yes 2 V No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Vital Be examiner? Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28d Describe how injury occurred 5 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Inhalation of car exhaust Natural FOUND: Division 1 Yes 2 V No Pending filled in by the f hours after death. May 17, 2010 1230 hrs Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 10735 Homewood Road, Ellicott City, MD determined 24 hours a (Specify) Parking Lot Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 18, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

DHMH 17 Rev 1/2001

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 12. 2010 2:20 Ам Rose Marie Sudano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Home Baltimore Essex 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 11-03-1936 Country) 73 Maryland 216-32-3106 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the west years ment of Health and Mental Hygiene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Anne Arundel Maryland Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 302 Balsam Drive 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Adam Dombrowski Mary Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, Maryland 21146 Samuel B. Sudano - Son 302 Balsam Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05-14-2010 05-04-2010 ■ Burial 2 □ Cremation 3 □ Removal from State Important: I any injury or Department St. Stanislaus Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Mure mes Baltimore, Maryland 21214 23a. Part 1. Enter the discress, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate
Interval Between
Onset and Death
7 - 3 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cor sequer ce of;: that the death certificate be executed for use as the burial-trans attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown P.O. by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Division of Vital Records, 1 Yes 2 No 3 Probably Unknown page 2 should been 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 2 - No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work? 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD -BASTERN 709. NASBRM d 31. Date filed (Month, Day, Year) 32. Registral's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2010 MAY Lillian D. Siemek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORS Iorien Nursing Home of Bel
5. Social Security Number 6. Sex 7. Age Air Year If Under 24 Hrs. Air Bel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2**X** F 92 07/04/1917 Maryland Director 219-01-6185 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21050 Funeral 312 Montgomery Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify. Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any injury or other traumatic event, the Magny injury or other traumatic event, the Magnones. Elementary/Secondary (0-12) College (1-4or 5+) School System 6 <u>Cafeteria Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Stankowski ၉ Paul Wlodarski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9203 Peach Blossom Avenue - Perry Hall, MD 21128 Doris H. Gierczak (daughter) 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 05/18/2010 | Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee A! Xas 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE disease or condition resulting in death) LUNG DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒Ño Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown HYPOTHYROLDISM has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy page After this certificate funeral director, page 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier.

State

Registrar

Milleram

DHANJANI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SIEMEK,

6225. UNION AVE

29c. License number

D45344

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			For State		State of	Marylar		artment of <i>tificate of</i>	Health and	Mental Hy			J	1579	1
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		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate or L	Calli		2. Date of De	Reg. No./ ath	UIU	3. Time of Death
Physic Med		Mable Jane Snipes	3					May May	I 6	2010	930 PM
Exam		4a. Facility Name (if not institution, give street and num	nber)		4b. City, Town, or					ounty of Death	
		3900 Arbor Crest Way 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast hirthday)	Rockvil	le, M		8. Date of Bir		Montgon	nery place (State or Foreign
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death item	Ē	11. Marital Status 12. Was Dece Armed Fo	edent Ever in U.S	3. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Orig	jin? (Spec	rify Yes or No-	14	. Race - Americ Black, White,	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any once.		19a. Informant's Name/Relationship (Type, Pnnt)		19b. Mailin	g Address (Street a	ın <i>d Number</i>	r or Rural	Route Numbe	r, City or To	wn, State, Zip (Code)
nd 2 s ealth m 27		Michael Snipes (Son)			Arbor Cre	st Wa	ay R	ockvil	le, Ma	aryland	20853
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Medical	29a. Certifier 1	sis of examination	and/or invest	igation, in my opinio	n, death occ	curred at t	he time, date a	ind place, ar	nd due to the cal	use(s) and manner stated
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Q		30. Name and address of person who completed caus	•		rint)		V			-+	
		Adrian D. Hurley, M.D. 31. Date filed (Month, Day, Year)	10810 C		icut Ave	nue I	Kensi	ington,	MD	20895	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral Director		220-24-7986	Sex 7. 1 □ M 2 🙀 F	Age (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Min. Ju	Date of Birth (Month, Day 1y 9,	1930	9. Birthp Cour Mary	place (State or Foreign arry) Land
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	Od. Inside City Limits
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980	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23s or 28e-1 show event, the Medical Exercitive motellied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force	as? █∑No			ent of Hisp ify Cuban,	panic Origin Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)	14. F	Race - Americ Black, White, city: Whi	etc.
Maryland 21215-0036	- 77	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)		0551	(Give	dent's Usua kind of wor DO NOT us	k done dui	on ring most o	of working			Business/In	dustry 1 County
212	filed with Hygiene. other ther	Com	12		oi 5+)	Admini	strat						e Depa	rtment
land	should be filed withir marked other than marked other than matic event, the Ma	To Be	17. Father's Name (First, Middle, La Nelson F.	st) Welle:	r			1		s Name (F oline	irst, Middle,		_{ame)} arff	
Aary	2 should and Men Is marker		19a. Informant's Name/Relationship Carla R. Solis (vn, State, Zip	Code)
	permit. Pages 1 and 2 should b Department of Health and Ment Importent: If Item 27 Is marked sny injury or other traumetic e once.		20a. Method of Disposition	Daughter /	20b.	Place of Dispo	sition (Nam	e of		Date	urnie,		n - City or To	own, State
Baltimore,			1 N Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe	city)	Lou	idon Pa	ırk Ce	meter	y 5/					Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Hom 3620 Wilkens Ave., Baltimore, MD 21229														
			23a. Part . Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	n line.							rest,		Approximate Interval Between Onset and Death
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9	tificate 19 physi as the	ledical	0.5	d										
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			30. Name and address of person wh	o completed cause of		m 23a) (Type,	,	(انجا	M	91117	,			
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ORIGINAL

DHMH 17 Rev 1/2001

10-03608 Mira Sandhu Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Control of Registrar Certificate of Registrar			2010 g. No.	5800				
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month	n Dav Year	3. Time of Death				
/ledical Exami	ner	Tilla Ballana	4b. City, Town, or Location of Deat	May 10, 20	10 4c. County of Death	1205 hrs				
		901 S. Bond Street	Baltimore							
Funeral Director		5. Social Security Numberunk 6. Sex 17. Age (In yrs. last birthday) 1 M 2 F 54 Yrs	If Under 1 Year If Under 24Hr Months Days Hours Mir	_	1055 Foreig	thplace (State or UNK in untry)				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits				
Maryland 28a-f show any 1 at once.	ŗ	MD Baltimore				1X Yes 2 No				
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?				
th the 23a or notifie		901 S. Bond Street	21231		USA					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		is Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - Ameri White, etc. Specify: Whi					
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	it's Usual Occupation (Give kind of							
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215-0036 be filed within 7 rtal Hygiene. rked other than ent, the Medica	mo	unk unk 17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname) unk					
215 be file ntal Hy rked o	Be				,					
MD 21; nd 2 should by the and Men nn 27 is mar	To		Address (Street and Number or Penn Street; Ba							
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Bal permi Depar Impo injur		21. Sig at e of Funeral S ice Licensee d S W 1 rector S S 3a. Pirt I. Enter the dislase, complications that caused the death. Do not enter if	lame and Address of Facility tate Anatomy Boa altimore Maryle			re Street				
Physician /Medical Examiner	t, shock, or heart	Approximate Interval Between Onset and Death								
LXammer		or condition resulting in death) Due to (or as a consequence of):								
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
ed nsit	Exam	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
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760, icate by physic the but		23b. Was decedent pregnant in the	. 🗀 -		23d. Date of delivery					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown								
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	edical	one) 2 Medical Examiner: On the basis of examination and/or investigate and manner stated.	theck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Mon</i> May 11, 2010	th, Day, Year)				
	-	30. Name and address of person who completed cause of death (Item 23a)	0.0							
		Ana Rubio MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 2120	l		,				
St Regist	× 0.0	31. Date filed (Month, Day, Year) 32. Regionar's Signature	ake							
DHMH 17 Rev 1/20	001	ORIGINAL		OCNE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** A^{M} 10, 2010 6:40 Dorothy Avilda Specht May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Casa De Rosa Savage Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) Months Days Hours Min. 1 □ M 2 🗓 F 214-50-5151 89 21, 1921 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No MD Howard Savage 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8306 Savage Guilford Road 20763 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2 💆 No Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ James Edward Keeney Vallie Virginia Hausenfluck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanny B. Specht / son 12010 Hall Shop Rd., Clarksville, Maryland 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Savage Cemetery May 14, 10 4 ☐ Donation 5 ☐ Other (Specify) Savage, Maryland 21. Signatur of Funeral Service Licens 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yieart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Conne (Final disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2100 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 Other (Specify 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed and P.O. Box 68760, Division of Vital Records, peen has certificate

burial-trar attending physician for use as the buria detached signed I within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Funeral

Director

show

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after

permit.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

Sta	te
Registr	ar

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a, Certifier

1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

1 ☐ Yes 2 ☐ No

Name and address of person who completed cause of death (Item 23a) (Type, Priot).

6 □ Could not be

determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

24 hours a

To the I within 2 To the I

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / E			Mental Hy	giene			- ^	
			Tioglottal	Certificate of I	Death		Reg. No.	10	15	<u>802</u>	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		Year			
	Medic	al	Mary K. Teves	Lu on T	- Landing of David				2:14	A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) Carroll County Gen. Hospital		r Location of Deat	n					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth				h	9. Birth	place (State o	or Foreign	
	Director		1 1 1 1 1 1 1	Yrs. Months Days	Hours Min.	6/13/	1939	Coun	ry) cyland	đ	
	T 80 41		Usual Residence of Decedent 10a State 10b County 10c City Town								
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	r 28a notif	Director	10e. Street and Number	ninster 10f. Zip Code			10- 04	A/b = A Cour		, 2 140	
	with th	ral	2436 Tyrone Road	2115	8			What Cour	nuy:		
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (S			e - Americ	can Indian,		
ō	ter de , or it	by F	1 ☐ Never Married 2 X Married Armed Forces? 1 ☐ Yes 2 X No	If Yes, specify Cuba		to Rican, etc.)	Accounty of Death Carroll				
3-00-cI	ursaf ural" al Exa		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No	Specify:		Specify	· Wh	nite		
7	72 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done	during most of wo	rking	Reg. No. 2 3. Time of Death 2:14 A M 4c. County of Death 2:14 A M 4c. County of Death Carroll 9. Birthplace (State or Foreign County) Maryland 10d. Inside City Limits 1 yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business Industry Retail Food 1ddle, Maiden Surmame) atterson umber, City or Town, State, Zip Code 15ter, Maryland 21158 20c. Location - City or Town, State Woodlawn, Maryland Funeral Home, Inc. 1timore, Maryland 21229 Approximate Interval Between Onset and Death a Cutte Chronic 23d. Date of delivery Month Day Year Approximate Interval Between Onset and Death a Cutte 23d. Date of delivery Month Day Year 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Kunknown Vas an autopsy findings available prior to completion of cause of death? 2 yes 2 x x x x x x x x x x x x x x x x x x				
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ם פ	lled w I Hygi othe	Be	17. Father's Name (First, Middle, Last)	71017	18. Mother's Na	me (First, Middle,			<u> </u>		
yland	Jenta Jenta Irked Ific ev	2	Francis Schwartz		Mary	T. Patt	terson				
Mar	shouk and N is ma auma	19	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street	and Number or Ri	ıral Route Numbe	r, City or Town, S	state, Zip (Code)		
	ealth m 27			2436 Tyrone	ROad, We	estminste	er, Mary	<i>r</i> land	21158	j	
ore O	t of H If ite or ott		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of cemeter	f Disposition (Name of ry, crematory or other pla	ce)	Date	20c. Location	· City or To	own, State		
paltimo	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ine Park Cer						ıd	
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i			23a. Part 1. Enter the disease, or complications that caused the death. Do n					lary L			
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	cate be executed physician and s the burial-transit	alE	resulting in death) Last Due to (or as a consequence of	Due to (or as a consequence or).							
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0	certific nding use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d Da	ate of deliv	erv		
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=	tth. : Afte	cate		njury wor		Zod. Describe ii	iow injury occurr				
VISIOII OI	Atter er deg ector by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far	rm, street, factory, office				er or Rura	l Route Numl	ber,	
2	tal or rs aft al Dir led in		building, etc. (Specify)			City or Tow	n, State)				
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as:	Medical	29a. Certifier 1 **Certifying Physician: To the best of my knowledge, (Check 2 **Medical Examiner: On the basis of examination and/o							anner stated	
	thin 2 thin 2 the I	Me	only one) 3	ledge, death occurred at the	ne time, date and p	ace, and due to the	e cause(s) and m	anner as st	tated.		
-	≒.≱ ₽8		but a security of the security	29c. Licens	7040						
			30. Name and address of person who completed cause of death (Item 23a) (1	MO						7	
			Howard G. Lanham, M.D. 215 Wa		Heights				2110/		
	Stat		31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	backer							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 5 Mary \mathbf{a}^{M} Taylor .0 2010 42 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore na Sinai Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year)
1-19-1918 1 M 2 K Days Min Country) 218-07-3714 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d Inside City Limits Director MD na Baltimore 1X Ves 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Ε. Federal Street 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐**X**No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black Specify 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) unk Continental Can Co Elementary/Seconday (0-12) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emmanuel Spruiell Ida Cotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Gordon Granddaughter 8432 Greenway Road Apt 4 Putty Hill, MD Carlette 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arbutus Memorial 5-19-2010 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Fune al Service Licensee any Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hrome disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Sid e and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

10-03447 James Thorpe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Thorpe		For State	Sta	ite of Maryla		irtment of <i>tificate of</i>		Mental	Hygiene	Reg. No.	201	0 580
Physician/		egistrar Decedent's Name	(First, Middle	,Last)		-	<u> </u>		2. Date of De Month		Year	3. Time of Death
Medical Examine	r	James Th	-						May 4, 2	2010		1125 hrs
	4	la. Facility Name (if 11379 Colur			imber)	4	b. City, Town, or L Silver Spring				c. County of Dea Montgomery	
Funeral Director	5	. Social Security N	umber unk	6. S ex	7. Age (In yrs. la 56		If Under 1 Year Months Days		Hrs. 8. Date of I		053 Fore	irthplace (State or UNK ign ountry)
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any	-		10b. County			Town or Locati						10d. Inside City Limits 1 Yes 2 No
and fshow	ξL	MD		gomery	S1.	lver Sp						
th the Maryland 23a or 28a-f sho notified at once		l0e. Street and Nun	nber				10f. Zip Code				tizen of What Co	untry?
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r death with or items 23		 Marital Status U Never Marrie 	$\inf_{\mathbf{Z}} 2 \prod_{\mathbf{M}} M a$	rried Armed F	orcestank		es, specify Cuban,			10	White, etc.	, ioan maran, siasi,
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		unk 17. Father's Name (First Middle	ui last) uple	nk		11	8.Mother's Na	ame (First, Middle	e, Maider	n Surname) un	k
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	ı١	I/. Faule 3 Name (T II St, Wildele,	unk								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		19a. Informant's Na	me/Relationsh	nip (Type, Print)			Address (Street					
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ore, stan of Hea	- 11	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State										ii Town, Glate
Baltimore, permit. Pages I an Department of Her Important: If ite		4 Donation 5 Noner Specify: in state										
Balt permit Departi Importinjury	1	21. Sign ture of Fu	neral ervice S	Wade /	irector	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	tate Ana	tomy B	oard; 65	55 W.	. Baltim	ore Street
Physician	Raltimore, Maryland 21201 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea											Approximate Interval Between Onset and
/Medical	ł	failure. List onl Immediate Cause (I		on each line. a. Athero	sclerot	ic card	iovascula	ar dise	ease com	plic	ated by	Death
Examiner		or condition resulting					ble gast					
<u>.</u>		Sequentially list con if any, leading to im	nditions, mediate	b Due to (or as a	a consequence o	f):						
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Box 68760, he death certificate be the attending physic hed for use as the bun the strength of the bun the strength of the bun the strength of the bun the strength of the str		IF FEMALE:		23c. If yes,	outcome or preg	nancy	<u> </u>	_		23	3d. Date of delive	
687 certific ading 1		3b. Was decedent past 12 months		1	birth nant at time of de		tal death 3 L her (Specify)	Ectopic pre	gnancy		Month	Day Year
the death certificate the death certificate by the attending phyched for use as the Drucsinian/M		1 Yes 2 1	No 9 Unk	nown 9 Unkn		5 Ot	ner (Specify)					
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after this certificate has reen signed by the attending physician and completely filled in by the funeral director, pag. 2 should be detached for use as the burial - transition: To Be Completed by Duverician/Madical E-		Part II. Other signi	ficant conditi	ons contributing t	o death but not re	esulting in the u	ınderlying cause g	iven in Part I.			o use contribute t	o the cause of death?
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To the Ho within 24 To the Fu completel	Medical	(Check only one) 2	Medical Exa	miner: On the basis and manner	of examination a	and/or investiga	tion, in my opinion	, death occurr	ed at the time, da	ate and p	place, and due to	the cause(s)
To To Sor	ğ -	29b. Signature and	title of certifie		o.arou.		29c. Licens				. Date signed (A	fonth, Day, Year)
		Moura	entre J	melhel	l		O.C.I	M.E.		Ma	ay 5, 2010	
	t	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
		Margarita K 31. Date filed (Mon			edical Examir Regis ar's Signat		enn Street, B	ailinioie, IV				
Stat Registra	~	J. Date filed (MOII	MAV	0 2010	, o olgilati	1	barker					

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		State of Maryland / [tment of H <i>ficate of L</i>		Mental Hy	0010			
100		Registrar 1. Decedent's Name (First, Middle, Last)	Certi	ncate of L	Jeani		Reg. No. 2. Date of Death 3. Time of Death			
Physicia /Medic		CATHERINE VELENOVSKY				Month MAY	14, 201			
Examin		4a. Facility Name (If not institution, give street and number)	4	lb. City, Town, or	Location of Death	1	4c. County of De			
**************************************		GENESIS PERRING PARKWAY 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	irthday)	PARKVIL If Under 1 Year	LE If Under 24 Hrs.	8. Date of Bir	BALTIMORE 9. B			
Funeral Director		. E. u. 277 E		Months Days	Hours Min.	SEPI.	3, 1913	rthplace (State or Foreign Country) MD		
ъ		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Loca	tion				10d. Inside City Limits		
Maryla f shov	JO.		IMORI					1 X Yes 2 No		
r 28a-	irect	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	Country?		
tth witt 23a o ust be	ralD	5315 PEMBROKE AVE		21206			USA			
DESILITIOFE, INISTY ISING ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 1. Yes 2. No			ispanic Origin? (Si an, Mexican, Puert	pecify Yes or No o Rican, etc.)		ite, etc.		
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DEMILITION DEMIL: Pages Department of mportant: If It any injury or o		4 Donation 5 Other (Specify) GARDE. 21. Signature of Funeral Service Ligensee		F FAITH		7/10	BALTIMORE,	AL HOME, INC		
Deperm Deperm any i		thing the		15 BELAI			, MD 21206	m none, in		
6		23a. Part1. Enter the disease of complications that caused the death. Do shock, or heart failure List only one cause on each line.	not enter	the mode of dyin	ig, such as cardiad	or respiratory	arrest,	Approximate Interval Between		
Physician		Immediate Cause (F) disease or conditio resulting in death) a.		Dechi	ne			Onset and Death		
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ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last		JOW	A Pie	eare				
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Or VITA Physiclan: this certific al director,	0 0	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/O	Outpatient	3 DOA Oth	or /		sidence 6 Other (S	pecify)		
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JIVISION I or Attending after death. Director: Afte	ertification:	3 Suicide 6 Could not be 28e. Place of injury - At home, f.	farm, stree			28f. Location	(Street and Number or own, State)	Rural Route Number,		
Ital or rs after ral Direction bed in b	Certi	4 Building, etc. (Specify)								
LIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledg (Check only one) 1 Medical Examiner: On the basis of examination a and manner stated.								
To th To th comp	Me	29b. Signature and title of certifer	40	29c. Licens			29d. Date signed (Mo			
			10		1464		5/14/1	0		
11		30. Name and address of person who completed cause of death (Item 23a) STOA(13 A . HASHMI MD, \$2(N . EU			le 3nd	RALTIO	nort mo	21261		
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		, 1 11	2007	5.10(11)		1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene 27 per dr., g903,05/20/2010dhb Certificate of Death 1 - For State Registrar Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Ye ar **Physician** CHAF 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE HO OMAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10–4–1964 9. Birthplace (State or Foreign Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday 5. Social Security Numb 579-02-0676 Funeral Days Hours Wash. DC Months 45 Director Usual Residence of Decedent 10d Inside City Limits 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evaminer must be notified at once. MD Upper Marlboro 1X Yes 2 □ No PG Director 10f. Zip Code 20774 10g. Citizen of What Country? 10e. Street and Number USA 11422 Honeysuckle Ct. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Myes 2 □ No
1 Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Human Resources 18. Mother's Name (First, Middle, Maiden Surname)
Cordell Bragg 17. Father's Name (First, Middle, Last) Ricardo Stephen Weaver, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11422 Honeysuckle Ct. Upper Marlboro, MD 20774 19a. Informant's Name/Relationship (Type. Print)
Joy Weaver/ Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National 20c. Location - City or Town, State Date 5-20-2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility onald Taylor II FII Sonature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 □Yes 2 □No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2/2 No 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5-Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State Registrar

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DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

Roger Olade, MD

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

Laurel Regional Hospital, Emergency Dept.

29d. Date signed (Month, Day, Year)

7300 Van

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAMES C. WALMSLEY MATY 2010 9:25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Feb. 17 1**X** M 2 □ F Hours , 1914 Maryland 218~32~1574 96 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director XX Yes 2 No Maryland Baltimore City Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 USA 4123 Southern Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Ares 2 □ No If Yes, Give WW1 1 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by White Maryland 21215-0036 Yes 2XXNo Specify: 3 X Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12th grade (0-12) Self-Employed TV Electronics Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Haupt James Carroll, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2902 Berwick Avenue Baltimore, Maryland 21234 Dennis Hager (Son-in-law) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 5-20-2010 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²Lassann Addres of Estat Home Tass ikn 7401 Belair Rd. Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner If any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 1 \square Yes 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 s autopsy performe 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

140, State

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Registrar

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32, Registrar's Signature

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CHARLES ST

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

MEUSSA TWOUF, CRYP (\$7.01)

WOLF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11:30 AM Billy Lee Wilson 18 2010 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday Months Days Hours 1936 West Virginia 74 April 5, 234-54-2253 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XYes 2 □ No Perryville Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21903-2010 2 Anchor Ct. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 ___No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2X Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Laborer 10 n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Glenice Hammons Earl Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2 Anchor Ct, Perryville, MD 21903-2010 Zella Wilson / Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/22/2010 Harford Mem. Gdns. Aberdeen, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. a Runeral Servic Licens 21. Signature 1 sancy 333 S. Parke St. Abordeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bladder Cancer Metastatic disease or condition resulting in death) Due to (or as a consequence of): Severa Thrombocytopenica if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Possible Metastalic Due to (or as a consequence of) certe IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at

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Important: If iter
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burial-trar use as s been signed to should be deta page 2 s certificate funeral director. this To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Physician/Medical Examiner

Completed by

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Medical Certification: To

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Acute Left Lower experiety all Ca, Bladder Ca, Hypertension

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 Suicide

4 Homicide

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

29c. License number

29b. Signature and title of certifier

MD

D0068014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASPIN J HUD, 500, UPPER CHESAPEAKE DR, BELAIR, MD-21014

State Registrar 31. Date filed (Month, Day, Year) MAY 20 201

6 Could not be determined

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 12 2010 9:55 Α Mildred Virginia Walker May 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Clarksville Howard Yolanda's Assisted Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2\XF 7, Yrs. Maryland Aug. 1912 212-30-1904 97 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Fulton Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20759 USA 8063 Murphy Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Manager 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eliza Elizabeth Murphy John Nelson Robey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hall Shop Road, Fulton, MD Gordon Frank Walker / Son 12620 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel UM Cemetery 5/15/2010 Scaggsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Weeks Metastatic Renal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin J Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2X No 1 ☐ Yes 🎾 No 1 ☐Yes 25. Was case referred to medical examiner? Assisted

permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nature" any injury or other traumatin mental pages. Physician /Medical Examiner

ending physician and use as the burial-trai

attending p

s been signed by the should be detached

After this certificate has funeral director, page 2:

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Be Completed

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

<u>ک</u>

Completed

Be

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Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be multified at

Physician/Medical

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

1 Yes 2 No

27. Manner of Death

31. Date filed (Mont

o medical						20. I lace of De	zaili (C	moon only one		
	Ho	spital: 1 Inpatient 2	ER/Outpatient	3 🗆 [Other	· 4 ☐ Nursing	Home	5 Residence	6 ☑ Other (Specify)	Assist Living
☐ Pending	,	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury Work? 1 □ Y	at es 2 □No	28d	. Describe how inj	ury occurred	

1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signatur

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

who completed cause of death (Item 23a) (Type, Print) and addres of perior

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State Registrar

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Registrar

ORIGINAL

10 ce Dundalle MD 21222

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2010 12:35 p.M Ayres Daniel Austin Medical 4c, County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Lexington Park Chesapeake Shores 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday Social Security Number **Funeral** Days (Month, Day, Year) 07/13/1953 Hours Min. Washington, DC 1 🕅 M 2 🗆 F 56 Director 214-52-2686 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director ms 23a or 28a-f s must be notified 1 Yes 2 X No California Maryland St. Mary's 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20619 USA 23528 Myrtle Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Union Elevator Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked o traumatic eve ၉ Myles Kathleen Rose Rolinson Ayres Danie1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 221, Bryans Road, MD 20616 John Hungerford/Personal Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Immaculate Heart of
Marv Burial 2 ☐ Cremation 3 ☐ Removal from State injury (05/13/2010 Lexington Park, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Service Licensee M01521 22955 Hollywood Rd., Leonardtown, MD 20650 Shawn Aylesworth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final Metastatic Bladder Carcinoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurral-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death Ectopic pregnancy Live Birth 2 - Fetal death 3 in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Lung Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No 2 XNo 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide building, etc. (Specify) City or Town, State) Medical

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State Registrar

29a. Certifier

(Check

29b. Signature ar

31. Date filed (Mo.

only one)

title of certif

Charles M. Benner,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

egistrar's Signatu

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0031563

20945 Great Mills Rd., Lexington Park, MD 20653

29d. Date signed (Month, Day, Year)

May 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Month Physician/ 1:36 PM Francis Flovd Abell May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year) January 18, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Months Days 1 X M 2 □ F 67 Yrs. 213-42-7905 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🗷 No Hollywood Marvland St. Mary's 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20636 USA 25389 Joseph Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Yes. Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Weather Station Owner 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henrietta Agnes Thompson John Louis Abell Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23267 Bayside Road, Leonardtown, MD 20650 / Niece Edie Woodburn 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Catholic Church May 12, 2010
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hollywood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Signature of Funeral Service Licenses Kenneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events GRAMOS Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should ! 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 \square Pending Natural Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Designing Projections. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rajbinderpal Singh Gill, 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State arks Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title/di

MD. 26840 Pt. Lookout Road, Leonardtown, MD 20650

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No:-2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Menth Year **Physician** VIO 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 9-14-1953 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ★M 2 ☐ F 216-58-6471 56 MD. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ntt. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD. CHARLES WALDORF 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 226 GARNER AVE. 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify. SpecifyWHITE δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WASHINGTON POST Elementary/Secondary (0-12) College (1-4 or 5+) NEWSPAPER MAILER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CURTIS LADD BIRLEY, SR. JUNE LAVERNE HICKERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUNE BIRLEY-SPOUSE 226 GARNER AVE. WALDORF, MD. 20602 If item 20b. Place of Disposition (Name of cermetery, crematory or other place)

ST. PETERS CEMETERY 5-14-201 WALDORF, MD. 20a. Method of Disposition 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 any i Mu 23a. Part 1. Enter the disease, or complications if at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Heart Failure **Physician** /Medical Left Venticular Assist Device Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗌 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? examiner? 1 Tes 2 No Hospital: 1 Inpatient Other: $_{4} \square$ Nursing Home 3 🗆 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) Certification: To this Manner of Death

1 Matural

2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗌 Yes 2 No filled in by the Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marked to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature an 29d. Date signed (Month, Day, Year) 2010 RES-000 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person G169014 Rushing 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 7, Day **Physician** Montell Blaine 5:07 РΜ Burgess Jr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown, Washington 18 West Baltimore Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11,1931 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 1 X M 2 □ F Months Days Hours 218-24-8925 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 18 West Baltimore Street 21740 items 23a U.S.A. 2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☐ Widowed 4 🗷 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Line Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Montell Blaine Burgess Jr. Daisy Catherine Stover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27976 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important; If Item 27 Is
any Injury or other trau Mary A. Wackowicz Daughter 591 Old Swamp Road, South Mills, North Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 05-09-10 Hagerstown, Maryland 22. Name and Address of Eacility Andrew K. Coffman Funeral Home, Inc. 40_ East Antietam Street, <u>Hagerstown, Md.</u> 21. Signature of Funeral Service Licensee L. hoel Brady Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 2 DIABETES Physician IYPE YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ The law requires 1 Yes 2 No HYPERTENSION HYPERLIPIDEMA 3 Probably 4 Unknown Completed HYPERTHYROLDISM TOBACCO ABUSE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has e 2 s autopsy page certificate 2 MNo Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number D58810 MAY 8 2010 OM. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12916 COWAMAR DRIVE SUITE 204 HAGERSTOWN MD 21742 STEVEN BLASH MD State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 MAY 5:18 P M ETHEL MAE WOODLAND BENNETT 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **CHARLES** LA PLATA CIVISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth ociober 25, 1937 Days Min Months Hours MARYLAND 220-32-6905 72 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7775 HAWTHORNE ROAD 20646 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: BLACK 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12TH GRADE ondary (0-12) College (1-4or 5+) LAW ENFORCEMENT CROSSING GUARD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES CORNELIUS WOODLAND LOUISE ELIZABETH SMOOT WOODLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3225 31ST. AVENUE, TEMPLE HILLS, MARYLAND DORIS C. BENNETT / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State JOSEPH'S CEMETERY MAY 8, 2010 POMFRET. MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lib sac THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN LYDIA C. THORNTON JOHNSON MOO583 HEAD, MARYLAND 20640 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not res 23e. Did tobacco use con ribute to the cause of death? ulting in the underlying cause given in Part I 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 □No 25. Was case. to medical eferre 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 1 2 ER/Outpatient 3 DOA Inpatient 27. Man r r of Death 1 v atural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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d other than "natural", or Items 23a or 28a-f show event, the Med cal Evaminer must be notified at

nd Mental Hygiene. marked other than

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Injury or other

Department of Heal Important: If Item 2 any Injury or other once.

filed within 72 hours after death

Pages 1 and 2 should be

Maryland 21215-0036

altimore,

Examiner Physician/Medical

burial-tran and attending physician for use as the buria signed by the a ş is certificate has been si director, page 2 should b Certification: To this funeral c

Division of Vital Records, P.O. Box 68760

Completed Be

Medical

2 Accident

3 Suicide

29a. Certifier

(Check one)

4 Homicide

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After filled in by the

Registrar

29b. Signate e and title of certifie

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (item 23a) (Typ

29d. Date signed (Monthy Day, Year)

Registrar's Signat 31. Date filed (Mor

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend Item 2 per me,g903,05/2012010dbbf Death Registrar Reg. No. 2. Date of Death 04/07/2010 Month Day Year 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:00 P^M 03 JAMES EDGAR BISANAR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner EASTON TALBOT 702 LOMAX STREET If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 08/08/1962 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Months 1 XM 2 □ F Yrs MARYLAND 47 214-50-4081 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at 1X Yes 2 □ No EASTON **Funeral Director** TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 702 LOMAX STREET 21601 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🗓 No þ 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Mudical Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPING 12 LANDSCAPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be .. Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked ott ijury or other traumatic aven JAMES M. BISANAR DIANE RENSHAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8597 WHEATLANDS ROAD, EASTON, MD 21601 DIANE R. BISANAR/MOTHER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If ony injury or once. 04/12/2010 STEVENSVILLE, MD CENTER 21. Signature of Edneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 Approximate Interval Between Opent and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASSOCIATED WITH POWER DRIVE Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 □Unknown 1 ☐ Yes 2 ■ No Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 No N 1 🗌 Yes 2 **1** No 26. Place of Death (Check only one Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 1 AYes 2 No el or Attending Physis after death.

J Director: After this ad in by the funeral d 28a. Date of Injury
(Month, Dry Y ar)

28b. Time of Injury
Wo
1

28c. Injury
28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 281. L cation (Street and Number or Rural Route Number, City or Town, State) -inflicted head injury 1 ☐ Yes 2 € No investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide Kesidence TOZ LOMAX SC, EASTON MD 21601 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

To the Hospitel o within 24 hours aft To the Funerel Di

The law requires that the death certificate be executed

O. Box 68760,

#289 Records, P.

Division of Vital

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with the Maryland

death

within 72 hours after

Baltimore, Maryland 21215-0036

23a or 28a-f ehow

Items!

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Hygiene.

O, DENTON MD 21629

29d. Date signed (Month, Dey, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)		. Date of Death	j. No.	3. Time of Death
	Physicia	_	Sandra Alice Billington		Month May	3 2010	7:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			20514 Georgia Avenue, Apt. 6	Brookeville		Montgo	omery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Y	(ear) 9. Birth	olace (State or Foreign
	Director		212-34-3400		Sept. 17	7 1949 Ka	nsas
	and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		-	Od. Inside City Limits
	Mary -f sh	ţ	Md. Montgomery Brook	keville			1 ☐ Yes 2 🔀 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	ntry?
	th wit		20514 Georgia Avenue, Apt. 6	20833		United Sta	ites
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	Vill To	2	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
)			- and mount	V42736		nay 3,	2010
	20		Dawn Broderick, M.D. 18109 Prince	o Print) Philip Drive, #275,	, Olney,	, Md. 2083	32
	Sta	te	31. Date filed (Month, Day, Year) 4 20 32. Registrar's Signature				
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State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Mont MAY 0 5 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 10 2010 Thomas Louis Bellere, Sr. 5:15 p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22978 Hopton Lane St. Mary's Leonardtown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **⊠** M 2 □ F Days Hours Director 03/20/1950 Yrs. 267-90-2610 60 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified a Maryland St. Mary's Leonardtown 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22978 Hopton Lane 20650 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceden. Armed Forces? 1 ☐ Yes 222 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify Completed 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Servant nd Mental Hygier marked other t Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bellere Louis Bowles Marv Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Thomas L. Bellere, Jr./Son P.O. Box 105, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd: 05/14/2010 Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Day Year signed by t. d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 X No 1 Yes 2 No Yes **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending n 24 hours after death.

Ne Funeral Director: Af pleted filled in by the fu 1 Yes Accident 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 Certifying Nurse Practioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D 33470 May 11, 2010 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Bhasker A. Jhaveri, M.D. 24035 Three Notch Rd., Hollywood, MD 20636 31. Date filed (Month, Day, Year) State MAY 13 2010 Registrar

DHMH 17 Rev 7/2009

		For State	State of	Marylan	-	artmen <i>rtificate</i>			and Me			0 1 0	5	8 Z U
	-	Registrar 1. Decedent's Name (First, Middle, La	st)			incan	o Oi I			2. Date of Dea	th		3 Time	of Death
Physic		Joseph Edward		Tr					'	Month	Day	Year		:36 AM
/Med		4a. Facility Name (If not institution, giv				4h. City.	Town, or	Location of	of Death	May	9,	2010 County of Death		. 30
Exam	mer	St. Mary's Hos				12. 01.7,		nardt			1	St. Ma		
Funera		Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	Voor	9. Birth	place (State	or Foreign
Directo		213-46-6803	M 2□F		$63\ {}^{ m Yrs.}$	Months	Days	Hours	Min.	(Month, Day lugust 24			intry) i ry1 and	
put 🔥		Usual Residence of Decedent		10- 0"	. T	- 4:							104 1	05-11-3
anyla shov	7	10a. State 10b. County 10c. City, Town or Location						Dowle				10d. Inside 1 □ Ye	s 2 K No	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at once.	Director	Maryland St. Mary's Lexington P								an of Milant Cour				
	Ö	20553 Springhill Road				101. Zip		0653			iog. Citize	g. Citizen of What Country? USA		
ns 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. 1	Vas Deced			igin? (Spec	cify Yes or No-	14	4. Race - Ameri	can Indian.	
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urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1∐Yes 2	2 🔀 No	Specify:			5	Specify: Blac	ck	
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d2s lth an 27 is		Sandra Barnes	/ Siste:	r	205	53 Spr	ingh	ill Roa	ad, Lex	kington I	r, City or Town, State, Zip Code) Park, MD 20653			
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Depa Impo	1	Kenneth Dhills										ardtown,		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death	n. Do not ent	er the mod	e of dyin	ıg, such as	cardiac or	respiratory ar	rest,		Approxim Interval B	ate
> Physiciar		Immediate Cause (Final	one cause on eac		iac	A179	- 4	the	nia			4	Onset an	d Death
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certifi ding se as	sician/Me	IF FEMALE:	23c. If yes, outco	me of pregna	incv						0,	Od Data of data		
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ng Pt fter tt neral	ļ.	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month)	Injury Day, Year)	28b. Time o Injury	f 2	8c. Injur Worl		2	8d. Describe h	ow injury	occurred		
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r Att	Certification: To	3 Suicide 4 Homicide Could not be determined determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu City or Town, State)								Number or Rur	ral Route Nu	ımber,		
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To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Lirector: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the b niner: On the bas and manne	sis of examina	wieage, aeat ition and/or ir	vestigation	, in my o	nie, date al pinion, dea	ath occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	∌(s)
o the vithin o the omple	Mec	29b. Signature and title of certifier	and maine	, oluleu.		290	: Licens	e number			29d. Date	signed (Month)	, Day, Year))
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me		30. Name and address of person who	-					- 1 3	-				-	
), .		Chandra Babu Sajja		035 Thr			Ho1	lywood	, MD 20	0636				

State

Registrar

31. Date filed (Month, Day, Year)

MAY 10 2010

32. Pegistrar's Signature

7. Age (In yrs. last birthday)

1946

12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No 1944

If Yes, Give

Year or Dates:

College (1-4or 5+)

89 Yrs.

10c. City, Town or Location

Hagerstown

Physician

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

19812 Bennie Drive

19812 Bennie Drive

1 ☐ Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

5. Social Security Number

Maryland

11. Marital Status

10e. Street and Number

188-09-5480

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

Washington

15. Decedent's Education (Specify only highest grade completed)

6 Sex

Wilbur Norman BLOOM

1⊠M 2□F

		Milton A. Bloom	E	Eva Lumn								
2		19a. Informant's Name/Relationship (Type. Print)	eet and Number or Rural Route Number, City or Town, State, Zip Code)									
	Ruth N. Bloom - wife 19812 Bennie Drive, Hagerstown, Marylan											
once.	20a. Method of Disposition 1 \(\text{\text{Burial 2}} \) Cremation \(5 \) Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place) 20c. Location - City of cemetery 20c. Location - City of cemetery 20c. Location - City of cemetery 20c. Location - City of cemetery, crematory or other place) 20c. Location - City of cemetery 20c. Location - City of cemetery 20c. Location - City of cemetery 20c. Location - City of cemetery, crematory or other place) 20c. Location - City of cemetery 20c											
once	2	21. Signature of Juneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 2.										
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
n al er	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
Examiner	iii c	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
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	1 2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of the pregnant at	Fetal deat	nancy fy)		23d. Date of d Month	elivery Day Year					
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Completed		24a. Was an autopsy performed? death?										
		25. Was case referred to medical		1 Ves 2 No 1 Yes								
Be	examiner?											
1∺	-	27. Manger of Death 28a. Date of Injury		4 ∐ Nursing Ho								
cation	1	1/ Natural 5 Pending (Month, Day, Ye 2 Accident investigation	Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
Medical Certification: To		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R City or Town, State)										
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Ž	2	29b. Signature and title of certifier	29c. L	cense number	29d.	29d. Date signed (Month, Day, Year)						
		De054451 May 10										
,	6	30. Name and address of person who completed cause of death 22911 Seffers on Bouleval	· c/	a) (Type, Print)	bug 111	uryland	21	783				
	3	31. Date filed (Month, Day, Year) 32. Pegistrar's	Signature	boal	J /	•						
State strar	ı	MAI EN KUIU LENGONOL	- Par									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

21742

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Min.

Hagerstown

Days

10f. Zip Code

1 ∐Yes 21∑ No

machinist operator

2. Date of Death

Month

18. Mother's Name (First, Middle, Maiden Surname)

8. Date of Birth (Month, Day, Year) Feb. 20,1921

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Mary land

12010

Washington

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

white

U.S.A.

Specify:

16b. Kind of Business/Industry

truck co.

8:20P M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ROBERT CHARLES BECKER MAY 8:45 PM 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11410 HAYMAN DRIVE PRINCESS ANNE SOMERSET 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Months Days Hours Min. NOV. 577-86-2787 19, 1957 D.C. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MARYLAND SOMERSET PRINCESS ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11410 HAYMAN DRIVE 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS BECKER FLORENCE OTTERBACK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA RODNEY BECKER/WIFE 11410 HAYMAN DRIVE, PRINCESS ANNE, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 5/3/10 DELMAR, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 1401343 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEPHROPATH MABETIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye an 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation

The law requires that the death certificate be executed nding physician and use as the burial-tran P.O. Box 68760, atter for u the a signed by t of Vital Records, this certificate

Examiner Physician/Medical nse ģ Completed Be Medical Certification: To

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified anone.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician: "
within 24 hours after death,
To the Funeral Director; After this certifica completely filled in by the tuneral director, p Division

State Registrar 29b. Signature and title of certifier

6 ☐ Could not be

determined

3 Suicide

29a, Certifier (Check only one)

4 Thomicide

D 48098

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiently in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Hall Highway, Confield, MD, 7/8/7

Location (Street and Number or Rural Route Number, City or Town, State)

acumbunathan,

32 Registrar's Signatu

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 PM Geraldine Lynn Cooper 4 2010 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hampstead 3121 Coon Club Road 8. Date of Birth Month, Day, Year) 10/17/1951 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday).
58 Yrs. 5. Social Security Number **Funeral** Days Hours 1 M 2 TKF 220-56-7911 PA. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Hampstead Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò death with 21074 3121 Coon Club Road USA or items 23a Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 ☒️No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white þ 3 ☐ Widowed 4 🔀 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) State of Maryland Inventory control supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Roecker Arlene Woodrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 Coon Club Rd., Hampstead, Md. 21074 19a. Informant's Name/Relationship (Type. Print) Ginger M. Bronke, daughter permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Md. 21074 5/5/2010 Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 South Main St., Hampstead, MD. 21074 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final - Physician CORDINA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of): Examir death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MIL 30. Name and address of person who completed cause of death (Item 231) (Type, Print) 10 PANSURIYA Malalm

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03668 State of Maryland / Department of Health and Mental Hygiene Vikel J. Cunningham 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1036 hrs May 12, 2010 **Medical Examiner** Vikel J. Cunningham 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 9. Birthplace (State or Foreign Virginia If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number **Funeral** Days Months Hours Min 218-11-8160 Director Country) 38 12/06/1971 1 X M 2 F Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 X No Havre de Grace 28a-f show imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21078 2094 Gemini Court Ö 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 X Married Yes Black 1 Yes 2 X No specify 3 Widowed 4 Divorced Yes, Give Year Specify: ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) **HVAC** 12 Technician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Gainey James Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2094 Gemini Court Havre de Grace, MD 21078 Cindy Cunningham / Wife Baltimore, Permit. Pages 1 and Department of Healt 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date Lakemont Memorial May 18, Burial 2 Cremation 3 Removal from State Davidsonville, MD 2010 (mportant: Gardens Donation 5 Other Specify. 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and one cause on each line Medical Death Immediate Cause (Final disease a Non ischemic cardiomyopathy Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical X UNPENDED certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial -AMENDED 23a, 27, per ME g904 6/18/10 TT Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate by 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Month Day Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No funeral director, page 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 / Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 1 X Natural 1 Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined within 24 ho

To the Func

completely f 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sal 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 15, 2010 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

Ana Rubio MD.

31. Date filed (Month, Day, Year)

tark

Assistant Medical Examiner

2. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Andrew John Calabrese 12:24 A^M May 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 2. 1 Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral 1**X**XM 2 □ F Months Days Hours Min. 216-48-9605 57 **Director** Maryland Jsual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medic I Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Directo Maryland Oueen Anne's Stevensville 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country?
U.S.A. 117 Touhey Drive 21666 Funeral . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst State Government 1 1 and 2 should be filed w if Health and Mental Hyg item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ John Joseph Calabrese Jacqueline Ramey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Judy Calabrese/wife 117 Touhev Drive Stevensville, Maryland or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 5/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Acute myocardial infarction disease or condition resulting in death) hours Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year Pregnant at time of death ed by the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed I should be det 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, hyperlipidemia, sleep apnea Records, 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed? Yes 2 N 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**XX**No 1 🗌 Yes ၉ 1 Inpatient 2 KKR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

317

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jamie Harms, MD

MAY 0 5 2010

31. Date filed (Month, Day, Year)

113 Sallitt Drive

32. Pegistrar's Signature

D41339

Stevensville, Maryland

May 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 :36 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ALTIMORE VA MEDICAL CENTE BALTIMORE 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ₹M 2 □ F Months Days Hours Min. Feb. 5, Year, 1947 MacyTand 63 214-46-5722 Director Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Knoxville Frederick Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 1313 Jefferson Pike 21758 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces 1 Yes 2 1 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Fueler Airline Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillie Mae Snoots Robert G. Caniford . Page 1 and 2 should b Iment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Jefferson Pike, Knoxville, MD 21758 Donna Caniford / Wife 20a. Method of Disposition
1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) 5/4/2010 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Frederick, MD 21702 1621 Opossumtown Pike, Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ TIL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year signed by the a 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an The law certificate has autopsy perform death? 2 X No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

16

N. GREENE

57.

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

32. Registrar's Signature

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TEMILOLU

31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 30 Day 2010 ALTHEA FAYE CAMPEN 10:09 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College View Nursing Center Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Days Hours Min FEB. 4, 1914 Director 172-12-7058 96 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Directo Maryland 1 ☐ Yes 2X No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8512 Guertin Court 21704 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 1 Yes 2 No should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Burton Given Amanda White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven D. Campen / Son 8512 Guertin Court / Frederick, Maryland Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cem. 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 5,2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific or heart failure. List only one cause on each line. Approximate Interval Between Imm Ji te Cause (Final disease or condition resulting in death) Onset and Death Physician/ Jemen +19 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 2 🗆 No Yes 21 or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-3-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederice. Hemen Thomas Sha 65 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 5 Registrar

P.O.

Cobert Thomas (of Marylar	nd / Depa	artment o	f Health				gible (1302
		Registrar 1. Decedent's Name (Fir	na Middle I se	4)	Ce	rtificate o	T Death			Re Date of Deat	eg. No.		16 70 (8)
Physicia Medical Examir				Garpen	ter					Month May 3, 20	Day Ye	ar	3. Time of Death 1644 hrs
		4a. Facility Name (if not 20242 Apt. B P			ber)		4b. City, Towr	n, or Location o	of Death		4c. County St. Mar		1
		5. Social Security Numb			. Age (In yrs. I	act hirthday)	If Under 1		er 24Hrs.	Data of Pic			thplace (State or Forei
Funeral Director		577 – 96–7994		M 2 F		48 Yr.	Months i	Days Hours	1		29, 196	C-	ountry) ryland DC
		Usual Residence of Dec	edent						11				
w any			County	•		, Town or Loca							10d. Inside City Limit
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	흱	MD Street and Number	St. Mar	y's	Gi	reat Mi	11S	to			0g. Citizen of W	hat Cau	
or 28	Funeral Director			D1	A 4-	D				1"	-		
with the same same same same same same same sam	曺	20242 Point 11. Mantal Status	L LOOKE	12. Was Dece	dent Ever in U		as Decedent of	0634 f Hispanic Orig	gin? (Speci	fy Yes or No	United 14. Race		ican Indian, Black,
death r iten	ine In	1 X Never Married	2 Married	Armed For	ces? 2X No	lf`	res, specify Cu	uban, Mexican,	, Puerto Ric	can, etc.)	Whit	e, etc.	
after	Š	3 Widowed 4		If Yes, Give Year or Dates:			Yes 2X				Specify:		ite
hour "natu Exan	ted	15. Decedent's Educat Elementary/Secondar		nly highest grade College (1-4			nt's Usual Occi nost of working				16b. Kind of B	usiness/	Industry
336 thin 72 se. than	ompleted	12	, (0-12)	Sollege (1-	- 01 0 .)	 Weld	er				Weld:	ing	
5-06 led wi Hygier other	ဦ	17. Father's Name (First	, Middle, Last)					18.Mother	's Name (Fi	rst, Middle, N	Maiden Surname		
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than	B	Richard Ala			Sr.	La con				Clark			
MD 2 d 2 shoul lth and M n 27 is m	의	19a. Informant's Name/F	, ,		-		•				ber, City or Tov		
and 2 and 2 dealth item 2 traum	ŀ	Frances S1 20a. Method of Dispositi	on	Siste	20b.	Place of Dispo	sition (Name of		D	ate	20c. Location		
Baltimore, permit. Pages I an Department of Hee Important: If itel		1 Burial 2 X C		_	Otate	crematory or of $tropoli$	• •		May	8, 10	Alovan	iria	, Virginia
altir mit. I partm portal	ł	21. Signature of Funeral	Service ce	se	Trie	22.1	Name and Add	ress of Facility					Funeral Ho
		23a. Part I. Enter the di	40	4		P.	O. Box	270, I	eonar	dtown	, Maryla	and	20650
Physician Maial Examiner		failure. List only on Immediate Cause (First or condition resulting in Sequentially list condition	disease a. death)	Athero Due to (or as a c	sclerot onsequence o	tic car		-			st, shock, of the		Approximate Interval Between Onset and Death
executed an and al - transit	al Examiner	if any, leading to immedicause. Enter Underlying (Disease or injury that in events resulting in death	Cause c.	Due to (or as a c									
9 g g	dical	X UNPENDED	X	AMENDED 9.23	a.27. i	per INF	/ME G90	04 6/14	/10 T	T.			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicing pletely filled in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 23b. Was decedent pregr past 12 months? 1 Yes 2 No 9			tcome of preg h nt at time of de	nancy 2 Fe	ital death her (Specify)		pregnancy		23d. Date of Month		Day Year
O. En at the d		Part II. Other significan	t conditions	contributing to d		esulting in the	underlying caus	se given in Pa	rt I.	23e. Did to	bacco use contr	ibute to	the cause of death?
b, P.O. ires that the signed by	g p									1 Yes	2 No 3	✓ Prob	ably 4 Unknown
of Vital Records, ag Physician: The law require this certificate has been sineral director, page 2 should be	Completed									24a. Was a autops perform	med?		topsy findings available ompletion of cause of s
Vital Reysician: The his certificate director, page	æ	25. Was case referred to examiner?		lospital:				lace of Death (
Physical din	의	1 ✓ Yes 2 2 27. Manner of Death	No	28a. Date of	niury	ER/Outpatient 28b. Time of		Injury at Work			Residence 6 ow injury occurr		: Scene
ion of tending Pheath.	틸	1 X Natural 5	Pending	(Month, D	ay,Year)			Yes 2					
Division ra for Attendi rs after death. al Director: /	Certification:	2 Accident 3 Suicide 6	Investigation Could not	pe 28e. Place o	of Injury - At he	ome, farm, stre	et, factory, offic	ce building, etc	c. 28f	. Location (S or Town, St		er or Ru	ral Route Number, City
Divi	딄	4 Homicide	determined	(Specify)					_ 4_	or rown, St			
To the Hospita within 24 hours To the Funeral completely fille	edica	one) 2 Medi	ical Examiner	an: To the best of On the basis of and manner stat	examination a		tion, in my opin	nion, death occ			and place, and d	ue to the	e cause(s)
	Σ	29b. Signature and title of	or certifier				1	ense number			29d. Date sign		nth, Day, Year)
		Yamely 1	ruthal	(114)	of do-st- (tr	22-1	1	C.M.E.			May 4, 201		
		30. Name and address o Pamela E. Sout	-	completed cause Assistant M	,	,	1 Penn Str	eet, Baltim	ore, MD	21201			
Sta Registi		31. Date filed (Month, Da	y, Year) 7 2010	32. Regi	strar's Signatu								
		L I A FI	1 CUIU	1	-)	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gyfford May Davidson Collins, II 4, 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1**X** M 2 □ F Days Hours Min. (Month, Day, Year) ar 31, 1938 **Director** Turkey 212-38-3604 Mar Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1510 Bradley Avenue 20851 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 9 Black, White, etc. Completed by 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White "natural", 3 Divorced Year or Dates. 1962-65 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Electronic Engineer</u> Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Collins Gyfford Davidson Ball Milnor Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia C. Collins/wife 1510 Bradley Avenue Rockville, Maryland 20851 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State any injury once. 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/7/2010 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Sign twie of Funeral Service Lies M00957 23a. Part Lenter the disease, or complications trial caused shoot or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Methicillin-Resistant Staphylococcus aureus Medical Due to (or as a consequence of Examiner Acute or Chronic Renal Failure Sequentially list our cities a Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Recent Herpes Zester Infection the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Ventricular Fibrillation Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year n signed by the a ld be detached f Yes 2 □ No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Diabetes Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Coronary Artery Disease autopsy performed? 1 Yes 2 No the Hospital or Attending Physician: funeral director, Be of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) · SIVA 1765312 5/4/10 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudarshan Siva 8600 Old Georgetown Road Bethesda, Maryland State

Registrar
DHMH 17 Rev 7/2009

Registrar

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

-1062

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 15831 State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4,2010 Charline K. Coakley М 9:30am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4982 Sentinel Drive #504 Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington DC 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 □ F Months Days Hours Min. Year) 1929 Director 577-36-2002 80 Dec Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1√ Yes 2 □ No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4982 Sentinel Drive #504 20816 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2X No 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contracting Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Menta fitem 27 is marked r other traumatic er George A. Kelser Sr. Alice Worthington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s Department of Health s Important: If item 27 i any injury or other tra Beverly Grubbs/Daughter 6739 Ford Rd. Frederick. MD 21702 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State National Crematory 4 Donation 5 Other (Specify) May, 6, 2010 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Lifensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List finly one cause on each line. 5130 Wisconsin Ave, N.W. - Washington, DC 23a. Part 1. Enter the disease Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No ate has been signed by the atte page 2 should be detached for Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No Yes 2 TyrNo 1 Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: 1 Yes 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 1 🔀 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ver Tom MD 0037655 May 5,2010 30. Name and addess of person who completed cause of death (Item 23a) (Type, Print) 15) pw Irving Veytsman, M.D. 110 Irving St., NW. Washington DC 20010 State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

10-03573 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rick Ray Conley State of Maryland / Department of Health and Mental Hygiene 2010 | 5832 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Da May 9, 2010 RICKY Ray 0357 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Min. 224-17-1812 10-13-1962 Director Country) 2___F Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10h Count Fredericksburg 1 Yes 2 No or items 23a or 28a-f show must be notified at once. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Rd. SA HOLL 980 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes Specify: White If Yes, Give Year 1 Yes 2 No specify: ment of Health and Mental Hygiene.

fant: If item 27 is marked other than "natural", or other fraumatic event, the Medical Examiner. 4 Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Baltimore, MD 21215-0036 aborer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Conley George Ray Blakeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) dericks
CONNER ROad burg 22906 mogine 19a. Informant's Name/Relationship (Type, Print) Blakelex Mom 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place) Fredericksburg. VA 05/13/201 Mercer Donation 5 Other Specify 22. Name and Address of Facility Found And Sons Funeral Chapel 21. Signature of Funeral Service Licensee sk workst m01080 10719 Courthouse Rd, FREDERICKSburg VA. 22407 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a Atherosclerotic cardivoascular disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of); Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED ted by the attending physician detached for use as the burial -AMENDED, 27, PII, per ME G905 7/22/10 TT The law requires that the death certificate be Box 68760. 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Hypertension, hypercholesterolemia, chronic Completed Records, 24a. Was an 24b. Were autopsy findings available obstructive pulmonary disease, and chronic autopsy prior to completion of cause of certificate has performed? death? page 1 🗸 Yes drug and alcohol use ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28c. Injury at Work? After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide

Hospital or Attending Physician: hours after death.
uneral Director; A within 24 hours at To the Funeral D completely

Registra

DHMH 17 Rev 1/2001

OCME 2006

Medical

29a Certifier 1

29b. Signature and title of certifier

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

200

32. Registrar's Signature

Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 10, 2010

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fannie M. Durham 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town or Location of Death 4c. County of Death comi 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Mrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Greece **Funeral** 1 M 2 X F Months Days Hours 5 (15/11926°ar) 579-26-0939 **Director** Usual Residence of Decedent 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Berlin MD Worcester 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Widows Watch Lane 21811 USA JURHAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify. 3 Widowed 4 XDivorced Specify. Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Washington Gas & Light Secretary and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael John Balamoti Agnes Papanotas 19a. Informant's Name/Relationship (Type, Print) FANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Rich O'Brien / Son-In-Law 6370 Country Club Dr., Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2010 Cape Henlopen Crem. Frankford, DE 21. Signat of Funeral Service Burbage Funeral Home 22. Name and Address of Facility 108 William St., Berlin, MD 21811 Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BRRBROVASCULAR CHRONIC ACCIDIZA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner WSUPFICIANCY Securitian liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 menths? Month Pregnant at time of death Day signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2/ No မှ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated partifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and litle of certifier DO05 8410 ress of person who completed cause of death (Item 23a) (Type, Print) E.T 6 gistrar's Signature State Registrar

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Daniel Anthony Dincher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

33C	Type of Finitin Di	ack maemble mk.	LIISUIC AII	Cobies Ale
	State of Maryland	Department of He	ealth and Me	ntal Hygiene

2	0	Marin Marin	0	-	5	8	3	

		1- For State Certificate of De	ath	Reg.	. No.	1303
Physiciar Medical Examin	n/	Decedent's Name (First, Middle,Last) Daniel Anthony Dincher		2. Date of Death	Day Year	3. Time of Death 2219 hrs
			fy, Town, or Location of Death nksburg		4c. County of Death Carroll	
Funeral Director		213-88-0392 1x M 2 F 46 Yrs. Mo	Under 1 Year If Under 24Hrs Onths Days Hours Min		Foreig	hplace (State or n untry) VA
Aaryland 28a-f show any I at once.		Usual Residence of Decedent 10a. State	Zip Code	100	. Citizen of What Coun	10d. Inside Cify Limits 1 Yes 2 No
h the Mau 3a or 28 otified a			21048		U.S.A.	
s after ural", o	by Fune	1 Never Married 2 Married Armed Forces? If Yes, sp 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No specify: ual Occupation (Give kind of v	Rican, etc.)	14. Race - Americ White, etc. Specify: White	te
5-0036 ed within 72 hour tygiene. other than "natu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of	ual Occupation (Give kind of Noworking life. DO NOT use reting Supervisor		6b. Kind of Business/Ir Tracor Inc	
	စ္က	17. Father's Name (First, Middle, Last) Charles Joseph Dincher	Mauree	(First, Middle, Ma n Ann Do	iden Surname) Lan	
MD 2. d 2 should lih and M n 27 is m	ľ	Mr. & Mrs. Charles J. Dincher 2837 Law	ress (Street and Number or F Indale Road, F	inksburg	, MD 21048	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is in injury or other trannation		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	mations 5/	13/2010	20c. Location - City or Hampstead,	MD
Ball permit Depart Impor		21. Signature of Funeral Services icensee 22. Name at 23. Part I. Enter the disease, or complications that caused the death. Do not enter the model of the disease of the death.	Pritts Funer	al Home a	& Chapel, I	P.A. MD 21157
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that coused the death. Do not enter the mo- failure. List only one cause on each line. Immediate Cause (Final disease a Cardiac arrhythmia	de of dying, such as cardiac o	r respiratory arrest	, shock, or heart	Approxima e n erval Between Onset and Death
LXammer		or condition resulting in death) Due to (or as a consequence of): Cardiomegaly b.				
	Examiner	if any, leading to immediate Due to (or as a consequence of): causar. Enter Underlying Gauss (Disease or injury that initiated				
ecuted and and - transit		events resulting in death) Last Due to (or as a consequence of): d.			2.000	
760, icate be executed physician and the burial - transi	Medical	IF FEMALE: AMENDED PI line a-b, PII, 27 23c. If yes, outcome of pregnancy	7, per EM g904	6/18/10	TT 23d. Date of delivery	10
Box 687(e death certifica the attending pt ed for use as the	sician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Fetal death pregnant at time of death 5 Other (\$ 9 Unknown		ncy		ay Year
S, P.O. B	ed by Phys	Part II. Other significant conditions contributing to death but not resulting in the underly Overweight	ying cause given in Part I.	1 Yes	acco use contribute to t	ably 4 🗹 Unknown
tal Records, Frian: The law requires is certificate has been sign ector, page 2 should be	Completed			24a. Was an autopsy perform 1 Yes 2	prior to co	opsy findings available ompletion of cause of S
ital Rec sician: The	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check DOA Other Nursin		esidence 6 🗸 Other:	Scana
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificate that the death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ation: To	1 Ves 2 No 1 Impatient 2 ENOutpatient 3 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28c. Injury at Work?	28d. Describe how		Gasilo
Divis spital or At nours after of neral Direc filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify)	tory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rur te)	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
Mar	Me		29c. License number O.C.M.E.		29d. Date signed <i>(Mon</i> May 13, 2010	th, Day,Year)
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201			
Sta Registr	_		,			
DHMH 17 Rev 1/20		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Hubert DAHLHAMER 2010 Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth May 13, 1929 Days Hours Min. 213-24-7899 1 🖾 M 2 🗆 F Months 80 Mary Land Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 17334 Claymont Drive 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

Yes 2 \sum No. Black, White, etc. 1951 ō þ 1 Never Married 2 Married hours after If Yes, Give Year or Dates 1 Yes 2X No Specify. white "natural", 1953 Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) sales and service business machines traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Loyd W. Dahlhamer Mary Golda Kershner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gloria Dahlhamer - wife 17334 Claymont Drive, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 13 2<u>010</u> 1 X Burial 2 Cremation 3 Removal from State May Rest Haven Cemetery 4 Donation 5 Other (Specify) Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ocardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hour Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami requires that the death certificate be executed and-tran Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical ding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 XN page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 4 hours after death. work? 1. Natural 5 Pending injury 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as tated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier peted (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 8 000 30. Name and address of person 14-12+

State

Registrar

31. Date filed (Month Da

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

egistrar's Signature

2010

10-03748 Brian Scott Ecker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar		, ,	g. No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death Month		3. Time of Death
edical Exami	iner	Brian Scott Ecker		May 15, 20	010	2104 hrs
4		4a. Facility Name (if not institution, give street and number) Carroll Hospital Center	 City, Town, or Location of Dea Westminster 	ath	4c. County of Death Carroll	
Funeral		Social Security Number	If Under 1 Year If Under 24H	Irs 8 Date of Birth	h(MM/DD/YYYY) 9. Birth	onlane (State or
Director				lin.	Foreign	1
		182-50-4472 1 M 2 F 45 Yrs. Usual Residence of Decedent		Sept.	20,1964 cou	ntry) PA
any		10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
nd show	Ä	PA York Stewarts	stown		_	1 Yes 2 No
Maryland 28a-f show any d at once.	Director		10f. Zip Code	10	g. Citizen of What Coun	try?
ith the days or notified	ā	17498 Barrens Road North	17363		USA	
D 21215-0036 should be within 72 hours after death with the Maryland and Mondal Hygien winstural", or items 23a or 28a-f sho 7 is marked other than "natural", or items 23a or 28a-f sho saite event, the Medical Examiner must be notified at once.	Funeral		Decedent of Hispanic Origin? (14. Race - Americ White, etc.	an Indian, Black,
	Fun	1 Yes 2 X No	_	to radan, etc.)		
rs afte aral",	ρ	or Dates:	res 2 X No specify: s Usual Occupation (Give kind o	fundidas I		ite
2 hour	ted		st of working life. DO NOT use re		16b. Kind of Business/In	dustry
36 thin 7 than than edical	Completed		oreman		Construc	rtion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	So	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
121 be fill ental I erked	Be	Charles A. Ecker	the state of the s	da L. Jo		
D 2. should and Mu atic e	7		Address (Street and Number of			
≥ 5 # 5 # 5	U d	Brenda L. Ecker/Spouse 17498	Barrens Rd	N. Ste	Wartstown 20c. Location - City or T	, PA 17363
Baltimore, bermit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or othe Cremat	r.place) Ma	ay 18,		Own, State
timen rtant		4 Donation 5 Other Specify: Direct Se	ervice '	2010	York, PA	
Bal Dermi Impo			me and Address of Facility J. S. Main St.			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	·			
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	nine	cause. Enter Underlying Cause (Disease or injury that initiated				
ed isit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
Sox 68760, death certificate be executed to attending physician and for use as the burial - transit		d. UNPENDED AMENDED				-
K 68760, n certificate be en ending physiciar use as the burial	Medical				Lood Date of deliver	
1876 rtifica ing ph		23b Was decedent pregnant in the	I death 3 Ectopic pregr	nancy	23d. Date of delivery Month Da	ıy Year
Box 687 ne death certific the attending p	sicis	4 Pregnant at time of death 5 Othe	r (Specify)			
	Physician/	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I	23e Did toh	pacco use contribute to the	no cause of dooth?
F. P.O. ires that the signed by t	þ	CONTRIBUTING TO CONTRIBUTING T	lonying cause given in Fait i.		2 ✓ No 3 Proba	
ds, equire een si	Completed			. 24a. Was a		psy findings available
COF law r has b	пр			autops perform	y prior to co	mpletion of cause of
Re: The ificate		25 Was area referred to westerd	00.51- (5. 11.0)	1 ✓ Yes 2	No 1 ✓ Yes	2 No
Division of Vital Records, real or Attending Physician: The law require all or a forestors. After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26 Place of Death (Check 3 DOA Other Nurs		Residence 6 Other.	
ing Phy After th	7	27. Manner of Death 28a. Date of Injury 28b. Time of Injury			ow injury occurred	
on endin ath.	tion	1 Natural 5 Pending May 15, 2010 1757 hrs	1 Yes 2 ✔ No	Operator lost	control of motorc	ycle
VISI or Att iter de birecte in by t	lica	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.		reet and Number or Rura	I Route Number, City
Dital o	Certification:	4 Homicide determined (Specify) Local Street		or Town, Sta 4903 Alesia Lir	ate) neboro Road, Manche	ster, Md.
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Sal C	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurre				
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number	ł	29d. Date signed (Mont	h, Day, Year)
		N-M-	O.C.M.E.		May 16, 2010	
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, N	MD 21201		
	tate		om oucet, baltimore, i	21201		
Regis	trar		erlas			

OCME

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	4	State of Maryland / Depart	iment of F ificate of I		-	~ ~ ~ !	0 1 0
		Registrar CC111	ilcate of t	Death	2. Date of De	Reg. No.	U 583
Physicia		1. Decedent's Name (First, Middle, Last)			Month	Day Yea	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4	lb. City, Town, or	r Location of Death	<u> </u>	4c. County of De	eath /
LAGIIIII	CI	NMS Healthcare of Humbur	Hails	Sown		Wash	in the
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs Jast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. E	Birthglace (State or Foreign Country)
Director		219-14-8918 14 2 88 Yrs.	, John Daye	Tiodic Min.	8. Date of Birt (Month, Da Jan. 17	7,1922 M	aryland
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion				10d. Inside City Limits
/ary।a	ō	Maryland Washington County Hagerstown					1 ☐ Yes 2 X No
the P 28a- notlfi	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What	Country?
3a or	ΙĒ	14014 Marsh Pike	21742			U.S.A.	
deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Argued Forces? 13. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever in	as Decedent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Race - Ar Black, W	merican Indian,
after or Ite		1 Never Married 2 Married 1 Yes 2 No	Yes 2 XNo	Specify:	o modifi, oto.)	Specify:	White
hours ural"	d by	3 Widowed 4 Divorced Year or Dates:	nt's Usual Occup	ation			- #- t - t
in 72 i "nar ledica	Sete	(Specify only highest grade completed) (Give kin	nd of work done of NOT use retired	during most of wor d)	king	16b. Kind of Busines	ss/industry
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Fire Fi		,		City Gove	rnment
al Hyg othe	Be C	17. Father's Name (First, Middle, Last)				Maiden Surname)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Mantal Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To	Charles J. Flook, Sr.				on Flook	
2 sho						er, City or Town, State	
1 and Health	2.9				Date	o, PA 1726	
ages nt of l		1 N Burial 2 □ Cremation 3 □ Removal from State cemetery, cremat			-2010	·	n, Maryland
artme artme ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) Rest Haver 21. Signature of Funeral Service Licensee 22. N				_	neral Home
Department once							, MD 21742
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the				0	Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition					Interval Between Onset and Death
/Medical		resulting in death) a. Due to (or as a consequence of):					-
Examiner	_	Sequentially list conditions. b.					
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Final line right of Cause (Disease or injury)					
be executed ician and burial-transi	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				-,	
	calE	d					
tificat g phy as the							
th cer endin	N/ue	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ec	ctopic pregnancy	,		23d. Date of	delivery
The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death 5 O	other (specify)			Month	Day Year
d by t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the under	arluina aguas aire	en in Dort I	220 Did t	obacca uso contribute	to the equal of death ?
ires the signe	by	Confestive Heart Failure	anying cause givi	en in Parti.		yes 2 No 3 ☐	to the cause of death? Probably 4 Unknown
requ been should	etec	C11.103/100 1/01.101					
ne lav e has ge 2 s	Completed				24a. Was autor perfo		autopsy findings available to completion of cause of ?
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/slcia	o Be	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient	3□ DOA Oth	_26. Place of Dea		dence 6 □Other (S	
g Phy er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injur Worl			how injury occurred	pecny)
ath. vr: Aff	atio	2 ☐ Accident investigation		Yes 2 □ No			
r Atto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	t, factory, office		28f. Location (3 City or Tox	Street and Number or vn, State)	Rural Route Number,
oital ours af			1				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. 29 the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifler (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death or check only one) 1 ★ Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my o	ppinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
Within Sompl	Me	29b. Signature and title of certifier	29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
18		Michelle Gille CRNP	RIL	8578		05-10-	-2010
241		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int)	<u></u>		^ -	
1		11 Detailed Month Day Vol. 22 Desired States	ihtike	Huges	Stown	MU217	142
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		J			
HMH 17 Rev 1/20	_	Loto please B. pps	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year rar le Medical 2010 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death 4c. County of Death £ Er 5.71 15altimore Social Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month: Hours (Month, Day, April 8 Country) Alabama 216-48-7185 **Director** 65 Yrs 1945 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Kentucky Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13636 Unionville Rd. 21791 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 11 Owner & Operator <u>Gutter Company</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. James R. Grumbine Edith Drake traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Edith Grumbine / Mother item 2 3636 Unionville Rd., Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Veasey Chapel Cemetery 5/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Covington Cunty, Alabama 21. Sign sure of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. Use only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ronard disease or condition resulting in death) av. Medical Due to (or as a consequence of per Garation Examine UNKLOOWN if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case Be referred to medical 26. Place of Death (Check only one) examilier? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No death. 2 ☐ Accident 3 ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 27 1 5, W

State

ne and address of person

31. Date filed (Month, Day, Year,

a. Kend

ause of death (Item 23a) (Type, Print)

ar's Signature

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan				Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death		Reg. No.	2010	15839
	Physicia	ın/	, , , , , , , , , , , , , , , , , , , ,					2. Date of De Month	Day	Year	3. Time of Death
*	Medic		GLORIA HAWKINS GOM 4a. Facility Name (if not institution, give street			# 07 T				010	_10:00a ^M
رر	Examir	ler	5002 Barnaby Lane	cald humber)		4b. City, Town, or		1		County of Death	
-	Funeral	Г	Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		If Under 24 Hrs.		th	ince Geo	orge's
	Director		085 - 28-0529	^{2 □} 73	Yrs.	Months Days	Hours Min.	(Month, De 7/11/	1936	I Count	ngton, DC
	d d	Ļ	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	etion					
	arylar a-fsh fied	Director		· ·							0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28	ä	Maryland Prince Geo	rge's Oxo	n Hill	10f. Zip Code			10a Citia	en of What Count	
	with t	Funeral	5002 Barnaby Lane			20745			_	ed State	
	tems er mi	E	11. Marital Status 12.	Was Decedent Ever in U.S		/as Decedent of Hi	spanic Orlgin? (Sp	pecify Yes or No-		4. Race - America	
9	ifter of ", or i	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	- 1	Yes, specify Cuba ☐ Yes 2 🔀 No		o Rican, etc.)		Black, White, e	
ğ	ours a fural	Completed	3 Li Widowed 4 152 Divorced	Year or Dates.					S	pecify: Blac	: K
က်	72 ho n "na Aedio	현	15. Decedent's Educat (Specify only highest grade o	ompleted)	(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation <i>uring most of wor</i>	king	16b. Kind	d of Business Ind	ustry
212	vithin jene. ir tha the h		Elementary/Seconday (0-12)	College (1-4 or 5+)		risory Co	ntract S	naciali	t C	0110 222	
פ	filed vall Hyg	Be	17. Father's Name (First, Middle, Last)	-	Daperv	1301, 00	18. Mother's Nar	•			
<u>Jar</u>	d be i Menta arked	욘	Lavolta William All	en_			Dorothy	Randal:	1		
Maryland 21215-0036	shou and is m		19a. Informant's Name/Relationship (Type, F		19b. Mailing	g Address (Street a	nd Number or Ru	ral Route Numbe	r, City or To	own, State, Zip Co	ode)
6	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Jewel A. Ingram / I			2 Barnaby	Ln. Oxo	on Hill,	Md.	20745	
			1 Seurial 2 ☐ Cremation 3 ☐ Rem		ace of Dispos metery, crem	ition (Name of atory or other place	e)	Date	20c. Loc	ation - City or Tov	vn, State
֡֟֝֟֝֟֝֟֝ <u>֚֚</u>	permit. Page Department. Important: It any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice see	Lin		<u>lemorial</u>		/2010		land, Ma	
Ra	Dep Impe		Tith O Sur	M01085		Name and Addres 38 Marlb					
Н			23a. Part 1. Enter the disease, or complicate	ons that caused the death						, Maryia	Approximate
P	nysician/	6 14	shock, or heart failure. List only one ca Immediate Cause (Final		12/12/2012						Interval Between Onset and Death
j	Medical		disease or condition resulting in death)	METASTATIC Due to (or as a consequence)		CANCER				-	
	Examiner	L.	Sequentially list conditions, b. =								
7	it c	nine	if any, leading to immediate	Due to (or as a conseque	ence of):						
1	and I-trans	Examiner	Cause (Disease or linjury that initiated events c resulting in death) Last	Due to (or as a conseque	ence off.						
7	cate be executed physician and s the burial-transit	edical								ĺ	
09/	physis the		d								
20 1	anding use a	N/n	Tebririan decoderit programme	f yes, outcome of pregnan ↑ ☐ Live Birth 2 ☐ Fetal	cy	F-4			23	3d. Date of deliver	v .
ROX ROX	ueatte ed for	Physician/M	1 Yes 2 X No	I □ Live Birth 2 □ Fetal I □ Pregnant at time of de I □ Unknown		Other (specify)	/			Month [Day Year
- 5	been signed by the attending I should be detached for use as		9 LI OTIKITOWIT		Discourse Alexander						
7. §	signec be de	l by	Part II. Other significant conditions contrib	uting to death but not resu	iting in the un	derlying cause give	en in Part I.			contribute to the	
lds	pluod	etec									ably 4 🗆 Unknown
Hecords,	has t ge 2 s	Completed						24a. Was autop	an osy rmed?	24b. Were autops prior to com death?	sy findings available pletion of cause of
Ž Å	ficate or, pag		25. Was case referred to medical			00.51		1 🗆 Yes		1 Yes 2	P √ No
Vital	s cert	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	tal: 1 ☐ Inpatient 2 ☐ E	:P/Outpationt	Other	ce of Death (Chec			7 au - 10 - 11 -	
O	ter thi				28b. Time of injury	28c. Injury	at	28d. Describe h		Other (Specify)	
ou	or: Aff	fica	1 🔀 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, real)	injury	M 1 □	∕es 2 ☐ No				
DIVISION	fter d	Certificate:	4 Homicide determined	Be. Place of Injury - At horn building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		lumber or Rural F	Route Number,
בּ בַּ	ours a		29a. Certifier 1 Certifying Physician	To the best of an in-				0			
H	within 24 bounds after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 2 Certifying Physician 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	In the basis of examination :	and/or investig	iation, in my opinior	 death occurred a 	it the time date a	nd place ar	nd due to the cause	a(e) and manner etated
Ę	withii comp	-	29b. Signature and title of certifier	1 4		29c. License				signed (Month, Da	
			· W	itte	-	10/	7906		5	151	10
-	wa		30. Name and address of person who comple	· ·		-	,			(/	
5	Stat	0	Dr. LOUIS KAFMAN, MD 31. Date filed (Months Day, Year)	. 12070 OLD 32. Pegistrar's Signatu		ENTER, #20	07 WALD	ORF, MAR	RYLANI	20602	
	Registra		MAY 0 7 2010	Divers 2	1 1	aled.					
				-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert L. Day Hearn 2:40 A 2010 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 21 Holly Road Severna Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** last birthday 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year)
(Month, Day, Year)
(Apr. 1932) 242-42-6677 1 🕅 M 2 🗆 F Months Days Hours Director Sep. Marvland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 21 Holly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 e filed within 72 hours after tal Hygiene. ed other than "natural", o White If Yes, Give 1, 952-54 Year or Date 1, 952-54 1 ☐ Yes 2X No Specify Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5± Education Teacher Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ellen Fossett 17. Father's Name (First, Middle, Last) Robert Labarre Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Holly Road Severna Park, MD 21146 Nancy Hearn / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. May 4,2010 Baltimore, MD Signature of Funeral Service Licensee Barrandodo & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pa. 1. Et a. th. discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death to thrive Physician/ Failure disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner 3 months neumonia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of CVA ate effects Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an te has k autopsy death? Yes 2 X No 1 Yes 2 No completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Prantioner: To the basis of my incoming at the time, date and place, and due to the cause(s) and manner as estated. (Check only r 29b. Signature 29d. Date signed (Month, Day, Year) R086053 050310 ress of person who completed cause of death (Item 23a) (Type, Print)

New port Drive Severne Yark 30. Name and add MO 21146 Lois Jane Schramek 213 Newport Drive 31. Date filed (Month, Day, Y State

DHMH 17 Rev 7/2009

Registra

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State of Maryland	Department of H	ealth and Me	ental Hy	niene	

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 7:30 A M Margaret Hobbs 2010 G. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3415 North High Street 01ney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 219-46-8752 101 Yrs. Director 1909 Maryland Usual Residence of Decedent filad within 72 hours aftar death with tha Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "neturei", or items 23a or 28a-f show treumatic event, Tra Nedical Exament rust be maiffed at Md. 01ney 1 ☐ Yes 2 KNo Montgomery Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 3415 North High Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 M No Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filad within nent of Health and Mental Hygiene. ent: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Myers Walter Groomes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3423 North High Street, Margaret L. Joyce / Daughter Olney, Md. item 27 other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importent: if any in ury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 Sunshine, Maryland Mt. Carmel Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home Xon Sau P. O. Box 5038, Laytonsville, Md. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MYOLARBIAL INFARLITON HOUR resulting in death) /Medical Due to (or as a consequence of): **Examiner** HYPERLIP IDEMIA HAM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed IN ER SION YELDY Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 ☐ Yes 2 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹No ² 1 Inpatient 2 ER/Outpatient 3 DOA SIL 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12594 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TACIOON 3416 ON MOUNTED COURT m SUITE 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 5 2010 **▶**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th g903 5-25-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 10:30 a.M Emma Beegle Harrison May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 40585 Valencia Court Leonardtown 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Hours Min 03/16/192 Country)
Pennsylvania 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40585 Valencia Court 20650 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1

X Yes 2

No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Charles Rhodes Beegle Margaret Eliza Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Harrison Fox/Daughter 40585 Valencia Court, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mount Zion United Methodist Church Cem 05/17/2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lothian, Maryland Signature of Funeral Service Doense 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. koch to Immediate Cause (Final 12120 Onset and Death

Ph sician/ Medical Examiner

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed

within 24 hours after death. To the Funeral Director; After this certificate has

Medical

Jyoti Shah,

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

ld be filed within 72 hours after death with the Maryland Mental Hygiene.

marked other than "natural",

permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I

Baltimore, Maryland 21215-0036

Examiner Be Completed by Physician/Medical မ Certificate:

disease or condition resulting in death)	a. Due to (or as a consequence	of:	30					
Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or ininiry	b. Due to (or as a consequence					, 4		
that initiated events resulting in death) Last	C. Due to (or as a consequence	of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown					23d. Date of de Month		Year
Part II. Other significant conditions of	contributing to death but not resulting	in the underlying ca	use given in Part I.	23		use contribute to		
				24	la. Was an autopsy performed?	prior to death?	utopsy findings completion of c	
25. Was case referred to medical			26. Place of Death (Che	eck only o	ne)			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/0	Outpatient 3 DO	Other: 4 Nursing	Home 5	Residence	6 🗆 Other (Spec	cify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not lead to the country of the country	(Month, Day, Year)	Time of injury M	c. Injury at work? 1 □ Yes 2 □ No	28d. De	escribe how inju	ry occurred		
4 Homicide determined		arm, street, factory,	office		cation (Street ar y or Town, State	nd Number or Ru e)	ıral Route Numi	ber,
(Check 2 L Medical Exam	rsician: To the best of my knowledge niner: On the basis of examination and se Practioner: To the best of my knowledge.	or investigation, in m	y opinion, death occurred	at the time	e, date and place	e, and due to the	cause(s) and ma	anner stated.
29b. Signature and title of certifier		29c.	License number		29d. Da	ate signed (Mont	h, Day, Year)	

24035 Three Notch Rd., Hollywood, MD 20636

5-13-10

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. Na. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:02 AM obert 0.5 09 Harris 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14014 (narsh Pike Hagerstown Washington NMS of Hacerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 XM 2 □ F Director 79 Sept. 1,1930 217-32-5862 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with ō 315 Jonathan St., Apt. A 21740 or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) than College (1-4or 5+) 8th Press Operator Printing n and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be 2 Unknown Ethel (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If Item 27 Is any Injury or other trau 443 N. Prospect St. Hagerstown, MD 21740

e of Disposition (Name of Date 20c. Location - City or Town, State Donna Harris / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Rose Hill Cemetery May 13, 2010 Hagerstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home <u>305 N. Potomac St. Hagerstown, MD 21740</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronar /Medical Du (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f g□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed been Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 1∐ Yes 2 No 2 No Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 📋 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pi n 24 hours after death. ne Funeral Director; After ti oletely filled in by the funeral 28c. Injury at Work? After 5 Pending investigation injury Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2

H-5

State Registrar

Stephanie

31. Date filed (Month, Day,

Comer 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Concordia CRNP 14014 Marsh Pike Hagerstown MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Eulalee Hyle 38 M Medical 2610 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PENINSULA SAUSBUK HICOMIC **Funeral** If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🔀 F Months Days 218-40-5809 Hours Min. (Month, Day, Year) 04/29/1929 Director 81 Virginia Usual Residence of Decedent and Mertal Hygiene.
Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Salisbury Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1704 Eastgate Dr., Apt. 306 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give white Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic 1 and 2 should be filed w f Health and Mental Hygii item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unknown) Louis Bowden Viola 19a. Informant's Name/Relationship (Type, Print)
Barbara Sabo/daughter 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 104 Barbara Ave., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot wicomico Memorial
Park 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 5 2010 Salisbury, MD 21. Signature of Funeral Service Licenses 24 Nami and Address of February Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ hroni disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Vear Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe certificate 2 🗌 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: ဥ 1 Yes 2 XNo 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A' 2 Accident
3 Suicide
4 Homicide 2 No the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon Powe Jav15 100 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1 7 RUSSELL MAY 2010 FRANKLIN HOWERTER 7:39 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 645 Knights Island Rd. Earleville Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 13 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 87 199-20-9755 1922 Director Pennsylvania Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Cecil Earleville 10e. Street and Number 10g. Citizen of What Country? must be n Glen 3 645 Knights Island Rd. 21919 Funeral U.S.A. 12. Was Decedent Ever in U.S.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural'; or items dical Examiner πι 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify þ Specify: 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Residential than the M Ith and Mental Hygiene.
27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be 2 Franklin Howerter Idella Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell H. Howerter (son) P.O. Box 346 Georgetown, MD. 21930 Department of Health Important; If Item 27 any injury or other to once. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Speciff) Kent Cremation 5/18/10 Smyrna, DE. 21. Signature of Funeral Service icen 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death Arteriosole **Physician** /Medical Due to (or as a consequence of): **Examiner** te251 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 res 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours aft the Funeral DI mpletely filled in 🖫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00035779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce Obenshain, M.D. 251 S. Bohemia Ave. Cecilton, MD. 21913 32. Registrar's Signature State

Registrar

3

amended item #8/5-11-2010/wchd/map
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i> i	rtment of F tificate of E			iene _{eg. No.} 2010	15846
	Discret-i-		1. Decedent's Name (First, Middle, La	est)				2. Date of Deat	h	3. Time of Death
	Physicia Medic		Naomi K. Ingram					Month 3	0- 2010 Year	7:10AM
	Examin	er	4a. Facility Name (if not institution, giv			4b. City, Town, or			4c. County of Deat	
	·		5. Social Security Number 6.		In yrs. last birthday)	SallS If Under 1 Year	OURLY If Under 24 Hrs		Wicon	
	Funeral Director		180-14-3407	1 □ M 2 🔀 F	88 Yrs.	Months Days	Hours Min.	(Month, Day,	1,2,/25/19250 , 2010 Penr	hplace (State or Foreign Intry) ISY1vania
	nd how at	۱	Usual Residence of Decedent 10a. State 10b. County		I Oc. City, Town or Loc	ation				10d. Inside City Limits
	faryla Ba-f s tified	ect	MD Wico	mico	Salish	ourv				1 ☐ Yes 2 🔀 No
	the N or 2	آق	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	s 236	Funeral Director	30819 Dagsboro	Road		2	1804		U.S.A.	
	r death or iterr iner n		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	lf.	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
Maryland 21245-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Importment of Health and Mentall Hygiene. Important: I fire Z is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Acal Examiner must be notified at once.	ed by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 🗷 No	Specify:		Specify:	white
2-0	2 hou "natu	Completed	15. Decedent's (Specify only highest of			ent's Usual Occupa		tking	16b. Kind of Business	Industry
12	thin 7 ane. than he Me	mo.	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)		9		
d 2	led wi Hygid other ent, t	0)	17. Father's Name (First, Middle, Last)	3	Homer	naker 	18 Mother's Nar	ne (First, Middle, M	Home	
lan	be fil fental rked tic ev	욘	Harry Knoeller				Esther		aldeli Sumame)	
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Address (Street a			City or Town, State, Zip	Code)
≥,	ind 2 s lealth m 27 her tr		Linda Reinert	(Daughter)		Dagsboro	Road S	Salisbury	, MD 2180	4
Baltimore,	ge 1 a nt of H : If ite or otl		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispos cemetery, crem	ition (Name of atory or other place	e)	Date	20c. Location - City or	Town, State
럂	iit. Pai intmer intant injury		4 Donation 5 Other (Spec		Riverside		-		<u>West Norri</u>	ton, PA
Ba	permii Depar Impor any in		21. Signature of Funeral Service Licer	04	22.	Name and Addres 13 East	. 91	ort Fune	ral Home Delmar, DE	19940
			23a. Part 1. Inter to disease, or con shock, or mart failure. List only	nplications that caused the	ne death. Do not enter					Approximate
P	hysician/	IJ	Immediate Cause (Final disease or condition		10 myo Proconsequence of):	THY				Interval Between Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to for as a	consequence of):					
	ted I	Examiner	cause. Enter Underlying Cause (Disease or linjury	Due to for as a t	onsequence or,					
	execu an and ial-tra	Exc	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
760	icate be executed physician and street transit.	edical	•	d						
587	ding p	/Me	IF FEMALE:	23c. If yes, outcome of	prograncy					
Box 68	attend for us	cian	23b. Was decedent pregnant in the past 12 conths? 1 Yes No		Fetal death 3 🔲	Ectopic pregnancy Other (specify)	y		23d. Date of del Month	ivery Day Year
B	the de by the ached	Physician/M	9 Unknown	g 🗌 Unknown						
Division of Vital Records, P.O.	ine de	2	Part II. Other significant conditions	contributing to death but	not resulting in the ur	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds,	equire een si ould b	Completed						1 □ Ye	es 7 No 3 Pr	obably 4 🗆 Unknown
<u>o</u> .	law re has bu e 2 sh	mple						24a. Was an autops:	y prior to o	copsy findings available completion of cause of
B	icate icate r, pag	õ	05 11/2					perform 1 ☐ Yes 2	ned2 death?	2,12 1100
/ita	siciar s certif irecto	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	□ rp/o	Otho	r: Che		R	11050168
,	g Phy erthis ieral c		27. Manner of Death	28a. Date of injury	t 2 ER/Outpatient 28b. Time of	28c. Injury	at	28d. Describe how	nce 6 Other (Speci w injury occurred	My HOSPICE
ou :	endin sath. or: Aft he fur	fical	Natural 5 Pending Accident Investigation		∕ear) injury	M 1 □	Yes 2 No			
Visi	To the Pospital or Attending Physician: The law within 24 burns after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s.	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		- At home, farm, stre Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui , State)	al Route Number,
	ours a ours a ceral C		29a. Certifier 1 Certifying Phy	vsician: To the best of m	v knowledge death o	coursed at the time	date and place of	and due to the cours		
:	ne Hoon 24 hoor 24 hoo	Medical	Check Medical Exan	niner: On the basis of exa rse Practioner: To the be	mination and/or investi	dation, in my opinio	a, death occurred :	at the time date and	I place and due to the c	ause(s) and manner stated
: 	Vithi To th		29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Month	
	0						0584	10	4/30/10	
	136		30. Name and address of person who	completed cause of dea	0 -	int)	CH. A	4		1 24 4 5
	Stat	e.	31. Date filed (Month, Day, Year)	32. Registrar's	BU T	1733	2/10/1	super	my 2	1802
	Registra			2010 Seneu	N. B. B	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 100013 WOUND A M 6415 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Anne Arundel Harwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth A (Month, Bay, Yea) 45 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min Georgia 259-68-3527 1 M 2 □ F 65 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 📉 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1916 C Copeland St. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates 968-70 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: Black ed other than "natural", event, the Medical Exa 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) C. Public Health and Mental Hygiene. em 27 Is marked other than ther traumatic event, Inc. M Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Housing 12th 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry J. Johnson Rosa Brewer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Johnson(Wife) 1916 C Copeland St. Annapolis, Md. 21401 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 5-10-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licenses Winname Resease of Scill Ons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** acciono disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Examir Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 🗷 No 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 6(277 4/29/10 MO 30. Name and ad ress of person with completed cause of death (Item 23a) (Type, Print)

State Registrar 31, Date filed (Month, Day, Year) MAY 0 5 2010

2. Registrar's Signature Denewa B. Saules

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auv

MO 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joan Crocker Johnson 2010 Рм May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice House <u>Harwood</u> Anne <u>Arundel</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. **Funeral** 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 1 □ M 2 🗱 F Months 12/17/1940 **Director** 231-54-0522 69 Virginia Usual Residence of Decedent 28a-f shov 10a, State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's 1 Yes 2 □ No Bowie 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 16014 Audubon Lane 20716 items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 11 Marital Statue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō 1 Never Married 2 Married Black White etc Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify "natural" 3 X Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher is marked other Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Curtis Armstead Crocker Violet Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Patricia M. Perez/ Daughter</u> 1410 Pinelake Lane Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 5/6/2010 21. Signature of Funeral Service License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 Months Physician/ Esophageal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown <u>Hyperlipidemia</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 No 1 Tyes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: မ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cher (Specify) Director; After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 05/05/10 D52139 30. Name and address of Serson who completed cause of death (Item 23a) (Type, Print) 2401 Brandermill Blvd. Suite 220 Gambrills, MD 21054 Sejal Mattu, M.D. State 2. Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 30, Day 2010 16:07 Adolphus Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country) Georgia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 D F Months Days Hours Min. June Pay, Year 946 Director 579-64-4853 63 Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Clinton Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 United States 10409 Laren Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify African American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Social Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Emma Walker Robert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important; If item 27 is 10409 Laren Lane Clinton, Maryland 20735 Mary Johnson/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Important; If any injury or ☐ Donation 5 ☐ Other (Specify) ee's Crematory 15/10/2010 Clinton, Md 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Erver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition acute Onset and Death Mys carried Physician/ Medical resulting in death) Due to (or as a co) sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician aruse as the burial-t Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Upper Gas hointestual Bleikin 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiper? 1 ✓ Yes 2 ☐ No Hospital: Other: 1 Inpatient 2 FR/Outpatient 3 IDOA 잍 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann J f Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funera 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 W Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0055120 12/2010 aru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Valmer mo

Rich and

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registrar's Signature

1328 southernavenue SE Suite 310 Washington DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 30, Day 2010 Lacey Eugene Jones 23:03 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 - F Months April 7, 1919 North Carolina Days Hours Director 579-12-2579 91 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1336 Varnum Street NE 20017 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Jones Vera Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent E. Jones/ Son 8704 Lolly Lane Clinton, Maryland 20735 injury or other Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC Part 1. Inter the diseas. In complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Va Navy Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy Hospital or Attending Physician: The 1 Yes 2 No ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 24 hours after death. Funeral Director: A 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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of Vital

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

05-01-2010

SE-DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EVAN MARCUS KELLEN 2010 30 023) M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersbux mont moundin Jerr LAUYES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** Days 1 MM 2 □ F JANUARY 22,1990 MARYLAND 218-27-6800 20 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23e or 28a-f show traumatic evant, the Medical Exercit at must be motified at Md. Gaithersburg Montgomery 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 United States 18523 Mountain Laurel Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education d 2 should be filed within 72 th and Mental Hygiene." 7 is marked other than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) В. Kellen Tamara Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) os 1 and 2 soft Health an Item 27 is 18523 Mountain Laurel Terr., Gaithersburg, Md. 20879 Tamara S. Kellen / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Ite any injury or otl 1 🗹 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/7/10 1 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Germantown, Md. 21. Sign up to f Funeral Service Licenze 22. Name and Address of Eacility Muriel H. Barber Funeral Home M-00470 Box 5038, Laytonsville, Md. P. O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No med? 22 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X esidence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Unt 1 Natural AJ1 30 2010 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3X Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide わりかて sicrel ter, Gail 24 hours a 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29d. Date signed (Month, Day, Year) 2010 HMO DIME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2191 mule call BRR SIE MID DONE Stuci Lilla sono W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hugh P. Knights May 2, 2010 05:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Hours Trinidad **Director** 455-04-8239 76 1934 Usual Residence of Decedent show 10a State 10h County the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f 1 X Yes 2 No Maryland Prince George's District Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6408 Halleck Street 20747 United States filed within 72 hours after death val Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Black, White, etc. Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Engineer Private event, Be 17. Father's Name (First, Middle, Last, should be file h and Mental F 7 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည Stephen Knight other traumatic Mary Jamison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Verdery Knights/ Wife 6408 Halleck Street District Heights, Md. 20747 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Harmony 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Landover, Maryland Memorial . Signature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE 20019 Washington, DC 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myo carbil nass luc disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day the 1 ☐ Yes 2 ☐ 9 ☐ Unknown g 🗌 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 DNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy pertorn death? certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 Wo Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မ 1 Inpatient 2 R/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completed filled in by the funeral 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide Investigation 1 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 05/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

MAY 0 7 2010

32. Registrar's Signature

10-03432	
Collegn I	Loughrey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 1585 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.								
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month Day	Year 3. Time of Death					
edical Exami	iner	Colleen Lynn Mowray Loughrey	May 3, 2010	2115 nrs						
		4a. Facility Name (if not institution, give street and number) Atlantic General Hospital	4b. City, Town, or Location of Deat Berlin		unty of Death cester					
Funeral		Social Security Number 6. Sex 7. Age (In yrs.)			YYYY) 9. Birthplace (State or					
Director		217-84-9987 1 M 2 X F 48	Months Days Hours Mil	0	Foreign					
		Usual Residence of Decedent	Yrs.	8/14/1961	Country) MD					
any			, Town or Location		10d. Inside City Limits					
<u> </u>	Ļ	MD Worcester Berlin								
Maryland 28a-f show <u>d at once.</u>	cto	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?					
death with the Maryland or items 23a or 28a-f sho	Director	10780 Cathell Rd.	21811	USA						
with the ns 23a se noti	ra	11. Marital Status 12. Was Decedent Ever in U	.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14.	Race - American Indian, Black,					
r death or iten must D	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.					
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Spe	city: White					
nours natur	pe t	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		of Business/Industry					
36 n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			0.1					
withi withingiene.	lmo	11 17. Father's Name (First, Middle, Last)	Owner/Operator		per Shop					
15- filed al Hyg ed ott	Be C	Patrick J. Mowray		e (First, Middle, Maiden Surr	name)					
21215-0036 Mult be filed within 72 hours after Mult by given in marked other than "natural", is event, the Medical Examiner.	.o B	19a. Informant's Name/Relationship (Type, Print)	Helen V 19b. Mailing Address (Street and Number or		Town, State, Zip Code)					
O 성 B is is	_	William A. Loughrey, Jr./husba								
ore, MEs I and 2 s of Health au If item 27		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)		tion - City or Town, State					
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Carloval Itolii State	pe Henlopen Crem. 5/5	5/2010 Frank	kford, DE					
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 Other Specify: Cd 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	rhage Funeral	1 Home					
Per Per in		DAM II) adjeud	108 William St., B	Berlin, MD 218	311					
Physician		23a. Bart I. Enter the disease, or complications that caused the death failure. List only one cause on each line.			or heart Approximate Interval					
/Medical Examiner		Immediate Cause (Final disease a. Asphyxia by hanging			Between Onset and Death					
LAdillilei		or condition resulting in death) Due to (or as a consequence of	f):							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	f).							
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause City of the standard of the stand								
sit d	xar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or or or or or or or or or or or or or	f):							
recute and - tran		d.								
760, icate be executed physician and the burial - transit	n/Medical	UNPENDED								
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg	nancy 2 Fetal death 3 Ectopic pregn.		ite of delivery ith Day Year					
Box 687 death certifi the attending	icia	past 12 months?			July 75th					
Bo e deat the at ed for	Physicia	1 Yes 2 No 9 V Unknown g Unknown								
s, P.O. Bc irres that the dea a signed by the a	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.		contribute to the cause of death?					
S, F					Yes 2 No 3 Probably 4 Unknown					
cords, law require has been sie 2 should b	plet			autopsy	4b. Were autopsy findings available prior to completion of cause of					
Records, The law requir ficate has been s	24a. Was an autopsy finding prior to completion of death? 1 Yes 2 No 1 Yes 2									
tal Recition: The coertificate	Be C	25. Was case referred to medical	26.Place of Death (Check only one)							
1 5 2 Z	0	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence	6 Other:					
n of V ding Ph	n: T	27. Manner of Death 1 Natural 5 Pending May 3, 2010 28a. Date of Injury (Month Pay Year) May 3, 2010	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury or Subject hanged self	ccurred					
tend teath.	atic	Natural 5 Pending Accident Investigation	1 Yes 2 No	oubject numged sen						
ivis or A after a Direc	tific	Suicide Could not be	ome, farm, street, factory, office building, etc.	28f. Location (Street and Nor Town, State)	umber or Rural Route Number, City					
2 October 2										
To the within To the comp	Medical	29b. Signature and title of certifier		<u> </u>						
	_	A	7 O.C.M.E.	May 4, 2	signed (Month, Day, Year)					
		course !		iviay 4,	2010					
ET 10		30. Name and address of person who completed cause of death (Item Zabiullah Ali, M.D. Assistant Medical Examiner		201						
	tate	31 Date filed (Months Des Veac) 32 Redistrar's Signatu	IFP 4							
Regis		MAY 0 6 2010	B. Darker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:10 p Edward William Lister, Jr. May 4, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House
5. Social Security Number 6. Sex 7. Age Carroll Westminster Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F Months Days Hours Min. Aug 20, 1940 Maryland Director 69 212-38-4349 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Westminster MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò or items 23a 21157 USA 1158 Canon Way Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1963 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced 1971 "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'n any Injury or other traumatic event, It & Med once. Legg Mason Elementary/Secondary (0-12) College (1-4or 5+) Wood Walker Vice President of Public Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward William Lister, Sr. Anna Panzer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1158 Canon_Way Westminster, MD Anne Lister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 5/5/2010 Hampstead, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA - K 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death HEART FAILURE Immediate Cause (Final disease or condition resulting in death) DNGESTIVE GTAGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 2 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** \mathcal{A} Marie lammy /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 3. Date of Birth (Month, Day Year) 1970 Pennsylvania If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X 166-48-9935 39 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10c. City, Town or Location 1 Yes 2 No Directo Adams County Biglerville PA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö "natural", or Items 23a o dical Examiner must be 17307 USA 160 Fairview Fruit Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XXMarried 1 ☐ Yes 2X Xio If Yes, Give Year or Dates: Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X XNo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry d other than "natur vent, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Newspaper Proof<u>Reader</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (fitem 27 is marked other other Be Julia Keller Frank Weishaar မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once. 160 Fairview Fruit Road Biglerville, PA 17307 Brian S. Mayers, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 17, 2010 Cashtown, PA Flohrs Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, MD 21783 23a. Park: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) venous thrombosis splenic ellac **Physician** /Medical **Examiner** mesenteric autery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ue to (or as a consequence of) physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy erformed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check only one Be examiner? Other: Hospital: 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 Impatient 2 ER/Outpatient မ 28d. Describe how injury occurred 28c. Injury at Work? completely filled in by the funeral 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural within 24 hours after death.

To the Funeral Director: After 5 Pending Injury 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide City or Town, State) Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KES 000 MAY 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 600 NORTH WOIFE St., BALTIMORE, MD, 21287 600 North Wolfe St, Baltimore, MD, 21287 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2, 2010 Georgene Minesinger 10:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Patuxent River Health & Rehab Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 0ct. 23 578-46-1483 West Virginia Director 85 1924 Usual Residence of Decedent 3a or 28a-f show be notified at uld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Prince George's Laurel 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23 6204 Forest Mill Lane 20707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'ury or other traumatic event, the Me Ohio State Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester E. Minesinger Sarah Rudolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maudie Loukota/ Sister 6204 Forest Mill Lane Laurel. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 5/5/2010 |Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) - aliure 10 Monday Medical Due to (or as a consequence of) Examiner Alzhermer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myselfell 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗖 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 X Natural injury 5 Pending Accider
Suicide Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check delins 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53411 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shesady 20715 Galland Fix Bows MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 0.5 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Janet Carolyn McGuigan 7:56 p May 1, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Emmitsburg Frederick 17041 Bull Frog Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 K F 220-34-5680 Director May 9, Iowa Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Predicel Examiner must be notified at once. Director 1 ☐ Yes 2 No Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17041 Bull Frog Road 21727 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1
Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: ≥ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theresa Bindseil Glen Hastings Reece 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coreen Kiser, daughter 35 Sullivan Ave, Apt B-1, Westminster, MD 21157 20b. Place of Disposition (Name of Scientific Crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 5/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD Carroll Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eest . disease or condition resulting in death) /Medical Due to (or as stonsequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 24 hours after death.
 Funeral Director; After this certificate h. performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIEN 31. Date filed (Month, Day, Year) 32. Redstrar's Signature Registrar

DHMH 17 Rev 1/2001

		For State	Flea	State of		nd / Dep		Health and N	лental Нус	jiene		15050	
Physicia	n/	Registrar 1. Decedent's Name	e (First, Middle,	Last)			rancate or L	Jean	2. Date of Dea	th Day	Year	3. Time of Death	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day HELEN JANE McKINSTRY 6:15A M MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT CANDLE LIGHT COVE **EASTON** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 - M 2 X F Days Min 86 10/25/1923 Yrs. INDIANA Director 319-40-0456 Residence of Decedent 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Ves 2 No MD TALBOT EASTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 27263 BAILEYS NECK ROAD 21601 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 XMarried ٥ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 Divorced 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic JOHN W. HENDERSON NORMA WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE M. DUNNINGTON/DAUGHTER 1703 CLAIR MARTIN PLACE, AMBLER, PA 19002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CULVER MASONIC CEMETERY 1 X Burial 2 Cremation 3 Removal from State 05/12/2010 4 Donation 5 Other (Specify) CULVER, IN 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. CHOi 200 SOUTH HARRISON STREET, EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. with sevene Dimeria Immediate Cause (Final CEnebroVASIVIAR Priysician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami physician and the burial-trans that initiated events resulting in death) Last by the attending physician Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) for Month Day Year signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an autopsy performed 25. Was case referred to m 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) 1 Natural 5 Pending

e Hospital or Attending Physician: The law 124 hours after death.
e Funeral Director: After this certificate has leted filled in by the funeral director, page 2.9 Division of Vital

Medical d Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IZRS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 LUDWIG J./EGLSEDER, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar Accident

3 Suicide 4 Homicide

Investigation

determined

6 Could not be

31. Date filed (Month, Day, Year) Registrar's Signature MAY 05 2010

503 CYNWOOD DR., EASTON, MD

1- For Amend Item 5 State of Maryland State McHD/SH 5/12/2010 per FH

Certificate of Death

giene		
Reg. No.		

Physician	
/Medical	
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Ever it with the profitted at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of I	Death	
an cal	Judith Ann McAndrew						20	10	9:06	P^{M}	
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town	or Location	of Death		4c. County of Dear					
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	5. Social Security Number -1.41 -40-8844 1 □ M 2 ▼ 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day, Y	(ear)	Cou	place (State or ntry)		
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ner	Sequentially list conditions, if any, leading to immediate cause. Litel Underlying Cause (Disease or injury that initiated events cause.	ence of):									
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ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of	death 3 [Ectopic pregna					ate of deliv onth		ear	
/sic	1 ☐ Yes 2 ☑No 4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5∟	Other (specify)						,		
Physi	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause	iven in Part	1.	23e. Did toba	cco use con	tribute to t	he cause of de	ath?	
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E E						24a. Was an autopsy performe			opsy findings a ompletion of ca		
ပိ	27 W					1 □ Yes 2 □		1 ☐ Yes	2 🗆 No		
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1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								fy)			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurred											
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edic	(Check only one) 2 ■ Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in m	opinion, de	ath occurre	ed at the time, date	e and place,	and due t	to the cause(s)		
M	29b. Signature and title of certifier		29c. Lice	nse number		290	l. Date signe	ed (Month,	Day, Year)		
Mutuer Millound MD 141667 5.10.1								10			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	Michael McCorneile III,		Nedica	10	mu.	Haje	riton	11	mo.		
ite ar	31. Date filed (Month, Pay, Year) 2010 32. Registrar's Signatu	ire	badel								
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State

Registrar

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			For State Registrar		State of M	aryland			nt of He te of D		Ment		ene. g. No.	010	100	O I
			1. Decedent's Name	(First, Middle, La	st)							ite of Death		Year	3. Time of D	eath
-	Physici /Medio		EV	elyn Mai	rie Nelso	n					Apr			010	11:30	p^{M}
>	Examir		4a. Fecility Name (I	not institution, giv	e street and number))		4b. Cit	y, Town, or L	ocation of Dea	th		4c. C	ounty of Death		
			3,0000000000000000000000000000000000000	ions Hea					Sykesv				ļ	Carroll		
	Funeral		5. Social Security N		Sex 7. Ag I□M 2 √⊡ √E	ge (In yrs. la		If Und Month:		If Under 24 Hrs Hours Min	s. 8. Da	te of Birth onth, Day,	Year)	9. Birthp	lace (State or i	Foreign
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	and		10a. State	10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City	Limits
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	3a ou	Funeral Director	1935 N	elson Rd					21157	,			1	USA	•	
	ms 2	Jera	11. Marital Status	CIBOII IM	12. Was Decedent	Ever in U.S	i. 13. y	Vas Dec		panic Origin? (, Mexican, Pue	Specify Y	es or No-		4. Race - Americ		
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiane. ed other than "natural", or itams 23a or 28e-f show event, the Medical Examinar must be notified at	by Fur	1 ☐ Never Marri	ed 2 Married	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:				-25	, Mexican, Pue Specify:	rto Rican,	etc.)	S	Black, White, Specify: Wh	etc. nite	
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Maryland	s 1 end 2 should f Heelth and Mer Item 27 is marke other treumatic		19a. Informant's Na	. ,				•					,	Town, State, Zip	Code)	
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Baltimore,	Pages hent of Hant: If Ite			☐Cremation 3 ☐	Removal from State		metery, crer	natory of	other place,	1	Date			ation - City or To		
Ħ	t. Pa rtmen rtent:			5 Other (Special		Dee	r Parl				4/201			lwood, 1		
Bal	permit. Pages 1 end Depertment of Heelth Importent: if Item 27 any Injury or other tr 9069.		21. Signature of Fu	meral Service Lice			41	L2 W	and Address	rton Rd.	itts . Wes	Funer tmins	al 1 ter	Home & (Chapel, 1157	PA
			23a. Part1. Enter ti shock, or hea	ne disease, or com rt failure. List only	plications that cause one cause on each	d the death. ine.	. Do not ent	er the m	ode of dying,	such as cardia	ac or resp	iratory arre	st,		Approximate Interval Between	een
	Physician		Immediate Cause disease or condition	Final n	Cerc	brov	asci	ala	V F	tccic	len	(-			Onset and De	ath
	/Medical Examiner		resulting in death)	(Due to (or as	s a consequ	ence of):									
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P.O.	that the de led by the a detached f	lysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐ Unknown			3 0 11.0. (
	Physician: The law requires that the death certificate be executed this certificete has been signed by the attending physicien and rall director, page 2 should be detached for use as the buriat-transit	by Pt	Part II. Other signif	icant conditions	contributing to death i	but not resul	lting in the u	nderlying	cause giver	in Part I.	2	3e. Did tob	acco us	e contribute to the	ne cause of dea	ath?
Records,	quires n sign	d D	- I-I ×	perer	Reni							1 □ Ye	s 2	No 3 Prot	ably 4 🗆 Un	nknown
8	w requir s been si should	Completed	,	,							2	4a. Was ar	,]	24b. Were auto	psy findings av	vailable
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ta	iclan: Th certificete rector, pag	0	25. Was case refer	red to medical						26. Place of De			No No	1 🗆 Yes	2 LI NO	
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	g Ph ter th		27. Manner of Deat		28a. Date of Inj (Month, Da	ury	28b. Time of Injury		28c. Injury			escribe ho			,,	
<u>.</u>	ath. Pr: Af	atic	♣ SNatural 2 □ Accident	5 ☐ Pending investigatio	n	., ,	,,	М		es 2 □ No						
Division	i or Atta efter de Directo	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	ijury - At hor tc. <i>(Specify)</i>	me, farm, str	eet, facto	ory, office		28f. Lo	ocation (Str ity or Town	eet and State)	Number or Rura	il Route Numb	er,
	To the Hospitel or Attending Ph within 24 hours elter death. To the Funeral Director: Atter th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exa	nysician: To the best miner: On the basis	of examinati	vledge, death on and/or in	occurre vestigation	d at the time	, date and place nion, death occ	ce, and de curred at t	ue to the ca the time, da	use(s) a	and manner as s place, and due to	tated.	
	To the within 2 To the complet	Mec	29b. Signature and	title of certifier	and manner s	iai o u.		2	9c. License	number		29	d. Date	signed (Month,	Dav. Yearl	
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	Sta	ite	31. Date filed (Mon	th, Day, Year)		rar's Signati		1								
	Registr			MAY () 4	2010 12.	*** * .	B ,	600	21							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Watgran 24 Department of the attn and Mental Hyglente? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 - 3 - 20 10 Physician/ 15:02p M Newman Proctor Hazel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince George 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Month Day, \ 5-26-Maryland Director 85 579-38-6363 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar most han material. 10a. State 10b. County 10c, City, Town or Location 10d Inside City Limits Director 1 Yes 2 No Brandywine MarylandPrince George 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 20613 10501 Cedarville Rd 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) \$t.Elizabeth Hospital Forensic Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Queen Bertha Richard Leonard Newman 19a. Informant's Name/Relationship (Type, Print) 10501 Cedarville Rd, Brandywine Maryland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Proctor/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5-13-2010Cheltenham, Maryland Maryland Veteran 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco Md, 20608 1589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. ARERIOSCIE Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day 1 Yes 2 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Prantianer: To the basis of any investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time occurred at the time, date and place, and due to the cause(s) and manner stated at the time occurred at the time, date and place, and due to the cause(s) and manner stated at the time occurred at the time. 29b. Signature and title of confile 29c. License number 29d. Date signed (Month. Day, Year) (Corner do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1701 Cringson Rost Fortwastington maybe TANKO Registrar's Signature 6 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 0 Physician/ Mav 4:50 PM Edith D. Pool Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Healthcare Charles County La Plata Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2**X**X 88 Months Days Hours Min. Director 235-56-8514 192 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WV Berkeley Kearneysville 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25430 2511 Charles Town Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 1 Yes 2 XX If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3₹Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) supervisor food service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Harrison Agnes B. Canfield Rapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Duffy/son 53 Hawick Rd. Inwood, WV 25428 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 🖾 Kurial 2 🗆 Cremation 3 🗆 Removal from State Summersville, 5/11/201 0 Memorial Gdns. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg, WV 25404 23a. Part 1. Enter the disease, or complications that caused the death. Do not e ter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau Interval Between Onset and Death JENU SCLENOSTS Immediate Cause (Final Physician/ disease or condition 141 Medical resulting in death) to (or as a consequence of) **Examiner** LE N. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 2 No 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item NH 5 31. Date filed (Month

State Registrar

		For	Plea	se Type or State o		nd / D		t of H	lealth and	Mental Hy	giene	2010	1 15864
Physicia		Registrar 1. Decedent's Name	e (First, Middi	le, Last)			Jertilicati	9 01	Deain ———	2. Date of De	Reg. No.		3. Time of Death
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Funeral		1135 Ocea 5. Social Security N		way Apt.	313 7. Age (In yrs	s. last birth	Ber	1 Year	If Under 24 Hrs	8. Date of Bir	th	orceste:	thplace (State or Foreign
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with the Maryland a or 28a-f show be mailfied a	tor	10a. State Maryland	10b. County Worce			ity, Town o	or Location						10d. Inside City Limits 1 ☐ Yes 2 ▼No
with the	Direc	10e. Street and Nu			212		10f. Zip				_	tizen of What Co	ountry?
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Modical Evantion in the mutified a	Funeral	11. Marital Status 1 Never Marr		Armed Fo	edent Ever in l	J.S.	13. Was Decedif Yes, spec		Hispanic Origin? (San, Mexican, Puer	Specify Yes or No to Rican, etc.)		SA 14. Race - Ame Black, Whit	
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within 72 ene. than "na he Wedic	Completed	Elementary/Seco	cify only highe	nt's Education est grade completed) College (1	-4or 5+)	_ (Give kind of wo life. DO NOT us	k done	during most of wo	rking			, made it
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permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, I'm Medical Once.		Heidi Tho 20a. Method of Dis	position	daughter 3 Removal from	20b.	Place of E	Disposition (Nar. crematory or o	ne of ther pla	own Rd.,	Date	20c. Lo	ocation - City or	Town, State
rmit. Pag spartment portant: y Injury		4 ☐ Donation 21. Signature of Fe	5 Other (S	Specify)	Ga	nesto	22. Name ar	d Addre	ess of Facility			escown,	Maryland
8979		23a. Part 1. Enter t	the disease, o	r complications that of	caused the dea	ath. Do no	501 Sno	W_H	uneral H Iill Rd., ng, such as cardia	Sailsbu	y, 1	Maryland	Approximate Interval Between
Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	a B			<u>Car</u>	25	~				Onset and Death
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hyslcian his certif	To Be	25. Was case referexaminer?		Hospital:	Inpatient 2[□ ER/Outp	patient 3 DC	Oth	or:	ath (Check only Home 5 Res		6 ☐ Other (Sp.	ecify)
ending P eath. or: After the funera	ation:	27. Manner of Deal 1 Natural 2 Accident	5 ☐ Pendir invest	igation	of Injury th, Day, Year)	28b. Tii Inj	me of 2 ury M	8c. Inju Wor 1 🗆	ryat rk?]Yes 2 □ No	28d. Describe	how inju	ry occurred	
tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could detern	not be nined 28e. Place buildi	e of Injury - At I ing, etc. (Spec	home, farn	n, street, factory	, office		28f. Location City or To			Rural Route Number,
	Medical	29a. Certifier (Check only one)		ng Physician: To the I Examiner: On the b and man									
Voir Court	Σ	29b. Signature and	title of certifie			C			se number	7	29d. Da	ate signed (Mon	nth, Day, Year)
181				who completed cause on , M.D.	se of death (Ite 120	em 23a) (T Pem	vpe, Print)		, Suite 1	01, Sal	isbu	ry, MD	
Stat Registra		31. Date filed (Mon		6 2010 32. F	Registrar's Sign	nature	Sparks	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Month April 30 05:03 A Robert Clayton Paris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, March 8 Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 🖾 M 2 🗆 F Months Director 578-38-9158 80 1930 DC Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Temple Hills 1 Yes 2 No Prince George's Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3905 23rd Parkway # 20748 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify African Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates American Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Parks and Recreation Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Howard Walter Paris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2077219a. Informant's Name/Relationship (Type, Print) Upper Marlboro, Md. 12816 Marlton Center Drive Darrell B. Wilson/ Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cheltenham 2010 Cheltenham, Maryland 22. Name and Address of Facility Stewart Funeral Home, Sid ature of Funeral Service 20019 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that shock or heart failure. List only one cause on pa complications that caused the death Approximate Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached 9 Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 1 Yes 21/2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mayner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t (Month, Day, Year) injury Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ure and title of certifier 29b. Signa 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

2. Registrar's Signature

Vitita 101

	•	for State Registrar			y		ertificate of				Reg. No	2011	J	00	000
Physicia	n/	1. Decedent's Name (First, Middle								2. Date of De	eath		3.	Time of [Death
Medic	al	Cere		izabeth	Pe	rry				April	29,	2010 Year	0	809	A.M
Examin	er	4a. Facility Name (if not institution Holy Cro					4b. City, Town,		n of Death r Sp1		40	c. County of De	ath gome	~ 37	
Funeral	-	5. Social Security Number	6. Sex	7. Aq	e (In yrs. la	st birthday	/) If Under 1 Year	If Und	er 24 Hrs.	8. Date of Bi		9. B	irthplace (Foreign
Director		578-44-7030	1 □ M 2	2 🖾 F	91	Yrs.	Months Days	Hours	Min.	Feb. 5	y, Year) 19	19 °	ountry)	DC	
od now	'n	Usual Residence of Decedent 10a. State 10b. County	,		10c. City	, Town or	Location						Tand In	nside City	/ Limits
arylar a-fst	ecto	DC			100.01.	, 101111 01		Was	hingt	ton				X Yes	
or 28 e noti	Dir	10e. Street and Number					10f. Zip Code				10g. C	itizen of What C	Country?		
with s 23a ust b	Funeral Director	1645 North Por	tal Dr	ive NW			1	20	012	i)	United		tes	
death item		11. Marital Status	l Ar	as Decedent E	ver in U.S	. 13	3. Was Decedent of I	Hispanic C	origin? (Sp.	ecify Yes or No Rican, etc.)		14. Race - Am		dian,	
after al", or xami	d by	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1	☐ Yes 2 🛣 Yes, Give	No		1 ☐ Yes 2 🔀 N			, ,		Black, Wh Specify: Af	riça	ın	
hours natura ical E	Completed	15. Decede	ent's Educatio			16a. Dec	cedent's Usual Occu	pation			16b. l	Kind of Busines	neric s Industry		
in 72 e. nan "r	duc	(Specify only high Elementary/Seconday (0-12)	1		i+)		ve kind of work done DO NOT use retired)					·		
d with lygien ther tl nt, the	Be C			ollege (1-4 or 5 5+			Educator				<u> </u>		vate		
ntal H red of	To B	17. Father's Name (First, Middle,	,	wd Dow	6 37			18. Mot		ne <i>(First, Middle</i> ea F1i 7		_{Surname)} h Short	er		
ould to		19a. Informant's Name/Relations		rd Per	L y	19b Ma	ailing Address (Street	and Num				·			
d 2 sh alth ar 27 is rrtrau		Linda Scope/ N					5 North P					ington,		200	112
of Hear		20a. Method of Disposition	•□•	16 00			position (Name of rematory or other pla	rei		Date	20c. L	ocation - City o	r Town, S	itate	
Page ment tant: I		1 ☐ Burial 2 🌠 Cremation 4 ☐ Donation 5 ☐ Other (Specify)	val from State		-	rematory	.00)	5-13	3-2010	Cl:	inton,	Md		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Simpature of Funeral Service	_icepses	(Qua)	1-1	M :	22. Name and Address 4001 Benn	ess of Fac	ility St	ewart F E Wash	uner ingt	al Home	In 200		
	î	23a. Part 1. Inter the diseas , shoot, or heart failure. List	r complication	ns that caused	the death	-								roximate val Betwe	
Physician/		Immediate Cause (Final disease or condition	-			ft F	oot Gangr	e n e						et and De	
Medical Examiner		resulting in death)		Due to (or as			oot oungi								
	er	Sequentially list conditions, if any, leading to immediate	b. —	Due to (or as a		onco of:							_		
red nsit	Examiner	Cause. Litter Underlying Cause (Disease or linjury		Due to (or as a	consequ	erice oi).									
execu in and ial-tra	Exa	that initiated events resulting in death) Last	c	Due to (or as a	conseque	ence of):									
tificate be executed ng physician and as the burial-transit	Medical		d												
∰ pos I		IF FEMALE:	T								Т				
ath cert attendin for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1	yes, outcome ☐ Live Birth ☐ Pregnant a	2 🔲 Fetal	death 3	Ectopic pregnar	су			Ť	23d. Date of do	elivery Day	Ye	ar
t the dea by the a rtached	hysi	1 ☐ Yes 2 ☐ YNo 9 ☐ Unknown		Unknown		calli J	Other (specify)			V					
that the property of the prope		Part II. Other significant conditi		-	ut not resu	ılting in the	e underlying cause g	iven in Par	rt I.	23e. Did t	obacco	use contribute t	o the caus	se of dea	ath?
v requires the special	edk	Aspiration Pn	eumoni	a						1 🗆	Yes 2	X No 3 □ I	Probably	4 🗆 Ur	nknown
I or Attending Physician: The law requires that the death car after death. Director: After this certificate has been signed by the attendi in by the funeral director, page 2 should be detached for use	Completed by	Dementia, Str								24a. Was auto	psy		completi		
ician: The la certificate ha rector, page		Congestive He 25. Was case referred to medical	art Fa	ilure							ormed? 2 X N	death?	es 2 🗆 I	No	
siciar certif	To Be	examiner? 1 Yes 2 No	Hospita	al:	0 🗆 1		ient 3 DOA Oth	ner:		k only one)					
ding Physic th. After this ce funeral dire		27. Manner of Death		a. Date of injui	γ :	28b. Time	of 28c. Inju	ry at	Nursing Ho	28d. Describe I		3 Other (Spe ry occurred	city)		
endin eath. or: Aft he fur	fica		gation	(IVIOITITI, Day	, rear)	injury		K? Yes 2[□No						
or Attendater deat Director: in by the	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e. Place of Inju building, etc		ne, farm, s	street, factory, office			28f. Location (d Number or Ri	ural Route	Number	5
pital o		20a Cartifiar 1 X Cartifuin	Physician	To the best of	mu len avele	das dast	h accuract at the time	a data an	d place as						
To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical I	Examiner: On	the basis of ex	kamination	and/or inve	h occured at the time estigation, in my opin	on, death	occurred a	t the time, date a	and place	e, and due to the	cause(s) a	and mann	er stated.
To th Withir Comp	-	29b. Signature and title of certifie					29c. Licens			3,70		ite signed (Mon		ear)	
			The				DO	0641	00		Ap	ril 29,	2010)	
מט		30. Name and address of person			,	, , , , ,			a .	363	200	010			
X		Smitha Bhikkaj: 31. Date filed (Month, Day, Year)	, MD	1500 I			n Rd. Sil	ver	sprin	ng, Md.	209	910			
Stat Registra	ar d	31. Date filed (Month, Day, Year)	010	82. Registra		ire Sa	4.1								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 0053 Reeves 2010 411 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6-eorges Cheverle rince If Under 1 Year If Under 24 Hrs. 9. Birthplace State or Foreign Social Security Number Age (In yrs. last birthday)
56 vrs 8. Date of Birth **Funeral** (Month, Day, Year) 8-30-1953 1 🛣 M 2 🗆 F Days Hours Months Maryland Director Yrs 215-62-8161 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 USA 5635 Piney Church Rd 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 72If Yes, Give 73 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Skilled Labor CRM Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Campbell F. Baker Hilda George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5635 Piney Ch.Rd, Waldorf Maryland 20602 Vanessa M.Reeves/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Maryland Veteran 5/12/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 20608 Adams Funeral Home Pa, Aquasco, Maryland 1589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Motor Vehicle Accider Ph sician/ Complications disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dien to (or as a nonsequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 Tyes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? ₁ ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examinera 1 Yes 2 No Other: 卢 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred STruck white pulling away from STop Sign Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 🔲 Natural 5 Pending 1 Yes 2 No 2/30 M Investigation MAY 2, 2010 Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Rd. 3 ☐ Suicide 4 ☐ Homicide 28e. lace of Injury - At home, farm, street, factory, office determined determined building, etc. (Specify)

STreet

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner asserted. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 00 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 gnd Solvad 31. Date filed (Month, Day, 32. Registrar's Signature State MAY 0 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death April Physician/ Rosalee Roberts 29 2010 11:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Bowie 2104 Pin Oak Parkway Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 DM 2 1 F Months Days Hours Min. April 192 Maryland **Director** 83 2-26-2744 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27: is marked outber than "natural", or items 23a or 28a-f sho amportant: If item 27: is marked outber than "natural", or items 53a or 28a-f sho amportant: If item 27 is marked outber than "natural", or items 5a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MarylandPrince George's Bowie 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 Pin Oak Parkway 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) 12th 3vrs Supervisor Comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas W. Thomas Charlotte Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Pin Oak Parkway Clara Colbert(Daughter) Bowie, Md. 20721 Baltimore, 20a. Method of Disposition 20b. Haceof Disposition (game of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 5-6-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Windame are and the second sec 821 West St. Annapolis, Md. 21401 mc0483 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARD disease or condition resulting in death) Medical Due to (or as a consequence of): Examine 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for se a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the detached g Unknown a Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an iis certificate has director, page 2 s autopsy certificate I Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ØNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 139 Old Solomons Island Rd. Annapolis, Md. Anthony M. Caputo, MD 21401

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 05 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiana

			For State State Registrar	n iviai yiai	-	tificate of l	heaith and i Death	,	JIENE Reg. No.	
	Physicia	an/	1. Decedent's Name (First, Middle, Last) Jeanne E. Ross					2. Date of Dea	th Day Ye	3. Time of Death
4	Medi Examir		4a. Facility Name (if not institution, give street and number of the st	nber)	Vo	4b. City, Town, o	r Location of Death		4c. County of	
	Funeral		5. Social Security Number 6. Sex	The Las	ast birthday)	If Under 1 Year	lighty If Under 24 Hrs.	8. Date of Birth	1 9	Birthplace (State or Foreign
	Director		217-46-1209 1 □ M 2 🖾 F Usual Residence of Decedent	62	Yrs.	Months Days	Hours Min.	09176	L947	Maryland
	yland -f show ed at	ctor	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
9)	the Mar or 28a e notifi	Director	Maryland Wicomico 10e. Street and Number	P:	<u>ittsvi</u>	10f. Zip Code			10g. Citizen of Wha	1 X Yes 2 No
2	th with I ns 23a must b	Funeral	34538 Old Ocean city R			2185			USA	
255, JEANN	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	Armed Fe	2 🔀 No ve		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. white
7.7	72 hor	mple	15. Decedent's Education (Specify only highest grade completed		(Give I	lent's Usual Occup kind of work done (O NOT use retired)	during most of work	ing	16b. Kind of Busin	iess Industry
	d withir dygiene ther tha nt, the	Be Co	Elementary/Seconday (0-12) College (-4 or 5+)	ager				insurar	ıce
V Z	d be file Aental H Irked of	10 E	17. Father's Name (First, Middle, Last) Howard J. Davis				18. Mother's Nam Elizak	e (First, Middle, Moeth M.		
Z	nd 2 should ealth and N m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Dominic Ross/son		19b. Mailin	g Address (Street 37 Whaley	and Number or Rura Ville Rd	al Route Number, Whale	City or Town, State YVILLE, N	1D 21872
Raltimore Manyland	t, Page 1 a tment of H rtant; If ite		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal fron 4 ☐ Donation 5 ☐ Other (Specify)	State	emetery, cren isbury	sition (Name of natory or other place Cremator	y 5 5	Date 2010	20c. Location - Cit Salisbur	cy, MD
a a	permi Depar Impo any ir	. 0	21. Signature of Funeral Service Liferine Joule Common Comm	(FT)	22	Name and Address 10110way 501 Snow	Funeral H Hill Rd.,	Home Pro	fessional ury, MD 2	l Association 21804
	Pnysician/ Medical		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause. Immediate Cause (Final disease or condition resulting in death)	erce	h. Do not ente					Approximate Interval Between Onset and Death
1	Examiner	L	Sequentially list conditions, b.	(or as a consequ	ience of):	9		•		
8	ted nsit	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or iinjury	(or as a consequ	ence of):					
	icate be executed physician and s the burial-transit		that initiated events c	(or as a consequ	ience of):					
68760	tificate b ng physic as the b	Medic	d							
Box	or the	Physician/Medical	in the past 12 months?	nant at time of d	I death 3	Ectopic pregnand Other (specify)	у		23d. Date o Month	
O 0	uires that the dea n signed by the a lid be detached f		Part II. Other significant conditions contributing to a		ulting in the u	nderlying cause giv	ren in Part I.			te to the cause of death?
Division of Vital Records	e law require s has been si ge 2 should	Completed by						24a. Was ai autops perforr	y prior	e autopsy findings available r to completion of cause of th?
<u>~</u>	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical examiner?			26. Pl	ace of Death (Check	1 Yes	2 € No 1 □	Yes 2 No
of Vii	g Physician: The lav er this certificate has eral director, page 2	은	1 ☐ Yes 2 Mo Hospital: 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2 O	28b. Time of	28c. Injury	4 ☐ Nursing Ho		nce 6 🔀 Other (S	pecify) Hospice
i	ttending death. tor: Aftr the fun	Certificate:	2 Accident Investigation	th, Day, Year)	injury		Yes 2 No			
Divis	tal or Airs after al Direct		4 Homicide determined	ng, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director. After completed filled in by the funer	Medical	29a. Certifier (Check only one) 1	sis of examination	and/or investi	gation, in my opinic	 n. death occurred at 	the time date and	diplace, and due to t	the cause(s) and manner stated
4	P /j		29b. Signature and title of certifler	10	The &	29c. License	9505		9d. Date signed (M	onth, Day, Year)
	Su	-	50. Name and address of person who completed cause	e of death (Item	23a) (Type, Pi	rint)				
	Star Registra	te ar	GREGORIO M. BELLOSO 31. Date filed (Month Pay) ead 6 2010 32. F	gistrar's Signati	ure f. A	ake	TAIL T VK.	SULIDE	MAY, MIV	21301

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ 13. Day 2010 RAMSBURG 6:05 Ам HILDA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 □ M 2 😾 F Months Days Hours Min. 219-20-4875 Maryland 1927l Director sept. Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Frederick Maryland Frederick 10f. Zip Code 21701 10e. Street and Number 10g. Citizen of What Country? 10110 Old Liberty Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Estella Moser Amos H. Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Altia L. Sherman, daughter 8023 Fieldstone Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet Cemetery May 18, 2010 1 XBurial 2 Cremation 3 Removal from State Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Lice 22. Reenetodand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 MO0255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Yes 1 DInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 14, 2010 D 54636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, M.D., 700 Montclaire Ave., Frederick, MD 21701 2. Registrar's Signature Barren) 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 288 for Maryland 6 Department 26 Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician Vincent Todd Silvestri 39 1504 M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bowie Health Pronce Cente Bour 6 copers 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 179-46-6411 1**X**M 2□ F Months Days Min 46 Director 6/04/1963 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Delaware Sussex Director Millsboro 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34275 Harbor Drive South 19966 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify White Completed by Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the School Teacher/Coach Education 7 is marked other traumatic event, if Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Vincent Bruno Silvestri Patricia Hills ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Patricia Wolfe/Mother 34275 Harbor Drive, Millsboro, Delaware Item 27 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of F Date 20c. Location - City or Town, State Department of Important: If It any Injury or c 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Atlantic Crematory 5/5/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, you Lituri 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asphyxiation disease or condition resulting in death) /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o be detached 1 ☐ Yes 2 ☐ No. 9 Unknown p σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Record 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page Vital 1 □ Ýes 2 □No 2- NO 1 ☐Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To o 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred if it or Attending Division To the Hosping.

within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Natural 5 Pending investigation Found: 2 Accident April 30, 2010 2:11p 1 Yes agnol 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 17604 Central determined 4 ☐ Homicide Avenue, Bowie, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11005

State Registrar 31. Date filed (Month, Day, Year)

300/ Hospita

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🗸 📗 U State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Jackson 2010 Emory Smallwood, Jr. 8:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 122 Tanager Court La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
June 21, 1935 Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Virginia 223-40-2916 Director 74 June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director Yes 2 No MD Charles La Plata 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 122 Tanager Court 20646 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 9 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Refrigeration Mechanic Food Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Jackson Smallwood Katherine Celeste Reamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Smallwood/Wife 122 Tanager Court, La Plata, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Popes Creek Baptist 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/3/2010 Baynesville, VA any injury once. 4 Donation 5 Other (Specify) 21. Signatu e Funeral 89 vice Licensee M00945 22. NARCHART-ECHOLS FUNERAL HOME, P.A. (cha aur Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Obstruction Pulmonary disease or condition resulting in death) Disease iran s Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Yes 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Ves 24 After this certificate within 24 hours after death.

To the Funeral Director; After this certific, completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bar{\textbf{X}} \) No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Projection in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 ЛC. MO PC359 2 April 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12020 OUD LINE CIMER, STE LOW WALDORF MD 20602 CASTRENCE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 20

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 4, Physician/ 2010 Lucille Sansalone 11:25A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery <u>Takoma</u> Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days (Month, Day, Year) Peb 11 1927 Min. Months Hours West Virginia Director Yrs <u>235-36-4443</u> 83 Usual Residence of Decedent 28a-f shov 10b. County 10a. State within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🙀 No Maryland Montgomery Silver Spring ò 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? 23a 3164 Adderley Court 20906 United States or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🏿 No If Yes, Give 1 Yes 2 No Specify: "natural" Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clerk permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiel Important: If item 27 is marked other t any injury or other traumatic event. the Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Morano Josephine Spine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ann Sansalone/daughter 3164 Adderley Court Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Journey Crematory 5/8/2010 Woodbine, Maryland Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ASPIRATION PNOUMENIA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 11METERS Examiner Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 2 N prior to completion of cause of death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-17874

Registrar DHMH 17 Rev 7/2009

State

12

Baltimore, Maryland 21215-0036

68760

P.O.

Division of Vital Records,

MD 20722

COTTAGE CITY

3717gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

S.M. NAYAR

	•	For State Registrar	State of Ma	-	epartment of Certificate of		R	eg. No. 20	10 1587	00-10
Physici		1. Decedent's Name (First, Middle, Last HILTON	Norwood	STA	NLEY		2. Date of Deal Month	Day	Year OR: 08 AM	A
/Medic Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deal		4c. County o	of Death	_
		DORCHESTER 6. Social Security Number 6. S	RENERAL 7. Age	(In yrs. last birth		RIDAE	8. Date of Birth		9. Birthplace (State or Foreign	n.
Funeral Director		220-12-0992	⊠ M 2□F		rs. Months Days	Hours Min.	04/16/	71925	MD Country)	
land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town					10d. Inside City Limits	5
e Mary ta-f sh	ctor	MD Dorche	ster	Cambr					1 X Yes 2 □ No	0
with the	Director	10e. Street and Number 1436 Cambridge	Beltway		10f. Zip Code 2161		1	USA	hat Country?	
death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indian, c, White, etc.	_
15-UU36 In 72 hours after death with the Maryland In aturai", or items 23a or 28a-f show edical Examiner must be notified at	by	1 ☐ Never Married	1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	0	1⊡Yes 24€N				Black	
Z15-UU36 thin 72 hours af e. an "naturai", or Medical Exam	letec	15. Decedent's E (Specify only highest gra	ade completed)		Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation e during most of wo red)	orking	16b. Kind of Bus	siness/Industry	
withi ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	A I	ymer Con		I	E.I. D	upont	
be filed tral Hygi od other event, t	Be	17. Father's Name (First, Middle, Last					ime <i>(First, Middle, i</i> ie Mollo		?)	
Maryiand to 2 should be file th and Mental H 27 is marked oth traumatic even	은	William Stan 19a. Informant's Name/Relationship (19b.	Mailing Address (Stre				State, Zip Code)	_
		Virginia M. St	anley/Wif	e 14	36 Cambr	idge Be			ge, MD 21613	}
Ore ges 1 tof H or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			Disposition (Name of y, crematory or other p				City or Town, State	
niti Pa nit. Pa artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Special 21. 2 gnature of Funeral Service Lice		veter	ans Ceme			Hurloc nith Fu	neral Home	_
Balt permit. Departi importi any inj	(A) 1	Tunet -	forh						Md. 21643	
	0 0	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lin	э.		ying, such as cardi	ac or respiratory an	rest,	Approximate Interval Between Onset and Death	
Physician //Medical		disease or condition resulting in death)	a. Due to (or as a	SE i	t).					
Examiner	L	Sequentially list conditions,	b	STA (HEAR	T FAI	LURE		
uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to historial cause. Enter Underlying Cause (Disease or injury that initiated events	Charlo (or da s	durady miner	.,				-	
6 exection and and urial-tra	Еха	resulting in death) Last	Due to (or as a	consequence	f):					
68760, ficate be executed physician and the burial-transit	edical		d							_
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and legge 2 should be detached for use as the burial-transit.	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		3 □Ectopic pregna	ncy		23d. Date	e of delivery nth Day Year	
P.O. E hat the dea do by the atteched for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify)			TWO!	Till Bay Tour	
s that to	by Ph	Part II. Other significant conditions					23e. Did to	obacco use contr	ribute to the cause of death?	
cords w require been sig should b			RESPIRA	TORY	FAILUR				3 Probably 4 Munknow	
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Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d	Be Co	25. Was case referred to medical examiner?					1□ Yes eath <i>(Check only o</i>	7	I ☐ Yes 2 🗖 No	_
Vision or Vital Re Attending Physician: The er death. rector: After this certificat in by the funeral director, pege	은	1 ☐ Yes 2☐ No 27. Manner of Death	Hospital: 1 Inpatie: 28a. Date of Injur	nt 2 ER/Ou	pallerit 3 DOA		Home 5 ☐ Resid	dence 6 Other		_
ion nding ath. r: After e fune	ation	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day on	Year) II		njuryat Vork? □Yes 2□No				
Division or i or Attending Phys after death. Director: After this i in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, fa . (Specify)	rm, street, factory, offic	ce	28f. Location (5 City or Tox	Street and Number vn, State)	er or Rural Route Number,	
Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p		(Check only 2 Medical Exa		examination an					anner as stated. and due to the cause(s)	
o the l	Medical	29b. Signature and title of certifier	and manner sta	ted.	29c. Lice	ense number		29d. Date signed	d (Month, Day, Year)	_
) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	M.	D .	D	69234		O 5	5/04/10.	
5+VA		30. Name and didress of person who	completed cause of de		Type, Print) 503 BY	RN STREE	ET, CAM	BRIDG!	E, MD 2161	13
St	ate	31. Date filed (Month, Day, Year)			pares	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/ 9(1)			
Regist	rar	MAY 05	UIU Pener	a p.	19 and					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 29 20TO EDNA MURIEL STEVENS 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death TALBOT WILLIAM HILL MANOR **EASTON** 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min 11/05/1912 MARYLAND 212-03-9867 97 Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 X Yes 2 □ No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ADIES APPAREL RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK STEVENS ANNIE ROYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET R. PERKINS/COUSIN 110 WEST OAK AVE., EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/05/2010 EASTON, MARYLAND SPRINGHILL CEMETERY 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOHOL MERC HARRISON ST., EASTON, MD 21601 of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kens IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No

Physician/ Medical Examiner

physician and s the burial-trans

attending p for use as t

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After this certificate har funeral director, page

neral Director: A

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Physician/

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r than "natural", or items the Medical Examiner mu

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permit. Page 1
Department of I
Important: If it
any injury or o

Page 1 and 2 Baltimore,

Physician: The law requires that the death certificate be executed

Hospital or Attending

Division of Vital Records, P.O. Box 68760

death with the Maryland ms 23a or 28a-f shormust be notified at

> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Month Day Year 23e. Did tohacco use contribute to the cause of death?

Physician/Medical 9 Unknown Part II. Other signifi þ Completed æ 25. Was case referred to medical |요 1 Yes Manner of Death Certificate: Natural Accident 3 Suicide 4 Homicide

29a, Certifie

cant conditions contrib	uting to death but	not resulting in t	he underlying caus	se given in Part I.
memia				

9 Unknown

	I ∟ res 2,2	3 Probably 4 D Offiction					
	24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death? 1 Yes 2 No					
of Death (Check or	ly one)						
4 Nursing Home	5 ☐ Residence 6 l	Other (Specify)					

5 Pending Investigation	(Month, Day, Year)	injury	М	28c. Injury at work? 1 Yes	2 🗆 N
6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		et, facto	ory, office	

1 Inpatient 2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	xaminer: On the basis of examination and/or investigation. Nurse Practioner: To the best of my knowledge, death.		te and place, and due to the cause(s) and manner stated. the cause(s) and manner as stated.
29b. Signature and title of certifier	Macronsley, Mi)	29c. License number 775933	29d. Date signed (Month, Day, Year) 4-30./D

the time, date and place, and due to t	the cause(s) and manner as stated.
nse number 775933	29d. Date signed (Month, Day, Year) 4.30.10

28d. Describe how injury occurred

30. Name and address of person who comp Michael D. Cros	eted cause of death (item 23a) (I	Type, Print) 610 Dutchmans Lave, Easton, MD 2160
31. Date filed (Month, Day, Year)	32. Registrar's Signature	

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check onl

Other:

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 \right Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2010 PM 5:17 George Melvin Stream Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 08/17/1932 1 XM 2 □ F Maryland **Director** 214-28-2458 ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Knoxville MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21758 <u>United States</u> 2725 Wolfe Drive "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. white 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) steel company welder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Stream Sarah Katherine (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2725 Wolfe Drive, Knoxville, MD 21758 Mary Stream / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/17/2010 Pt.of Rocks, MD Pauls Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home andulu la 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Inset and Death Ph sician/ 10WS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner aralo Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Examin law requires that the death certificate be executed Dreumon and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Brunswick , 610 Ninth awe

3 DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month **Physician** 2010^{ear} CARMEN FREDA THOMPSON 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Center Frederick | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Min. | Win. | July 15, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Maryland 1928 216-22-9627 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyYes 2 □ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 North Carroll Street 21788 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 24 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗐 No Specify: 5 Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Claire Frock 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Paul Wilbur DeBerry Luella Shriner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 South Market Street, Frederick, Maryland 21701 J. Ronald Pearcey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 5/4/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service Licensee ROBERT ant Address Tariy & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the da shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final emente h(EEH disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No

Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Hospital or Attending

and burial physician the as attending properties for use as signed by the a I be detached f been page 2 s certificate director, this After this funeral of e Funeral Director; Af letely filled in by the fur

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examinar mast by retified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) e of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

D0062223

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Praveen 'Bolarum, MD 196 Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year)

State Registrar

completely

within 2

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28b, per ME g903 5/24/10 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month 1148 Physician/ A M Preston Tarleton 04 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shock Trauma Center , UMMS Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth . Social Security Number 6. Sex. 1 ☑ M 2 ☐ F **Funeral** Month, Day, July 8. Country) Virginia Days Hours Min Ĩ986 216-21-9906 23 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits shov 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho rector 1 Yes X No Frederick Maryland Rosemont ō 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21758 United States 3624 Petersville Road items Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status and Mental Hygiene. is marked other than "natural", or iter raumatic event, t<u>he Medical Examiner</u> Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Warehouseman +4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mark Tarleton Hypatia Mullen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Petersville Road, Rosemont, MD 21758 Mark Tarleton / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1

→ Burial 2 □ Cremation 3 □ Removal from State Date Petersville, Maryland 5/5/2010 | Petersville, Stauffer Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 21. Sign/ture of Funeral Service Licenses 22. Name and Address of Facility 1100 North Maple Ave., Brunswick, MD 217±6 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Subarach noid cerebral Who works and the comme Physician/ dave hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner days Motor vehicle CrasL Sequentially list conditions, Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury signed by the attending physician and deed be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last CERTIFIC Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗌 No g Unknown 1 ☐ Yes 2 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗆 No 1 Yes 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 0010 jury 1 Alatural 2 Accident 5 Pending MVC True 1 Yes 2 No v. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At - 16 - 1010 +10 Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Route 180 of Route 79 Knoxsville Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MM 14476 - 30 - 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Ballimore 21201 Greene MD 22 S Timmons Iracy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Inka 5 Braskan. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	state of Maryl		artment <i>tificate</i>			nd M		giene Reg. No. 2	The state of the s	15879	
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) Bobbe J. 4a. Facility Name (If not institution, give street		urner	4b. City, To	wn or I	ocation of	Death	2. Date of Dea	Day 30 4c. County	Year 2010	3. Time of Death	
A.	Examir	ier	The Johns Hopkins Hosp			Baltim						N/A		
	Funeral Director		5. Social Security Number 6. Sex 1 X M		yrs. last birthday) 75 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birt Jan	^h 9 ^{Yea} 1935		lace (State or Foreign	
	f show	jo.	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	100	. City, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 X No	
	or 28a.	Director	10e. Street and Number			10f. Zip-Code 10g.				10g. Citizen of V	. Citizen of What Country?			
	ath wit 23a c ust be		8 Charles Plaza	210NT		21201				USA	USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2X Married	Was Decedent Ever in Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: 19(Was Deceder f Yes, specify □ Yes 2		panic Orig , Mexican, Specify:	in? (Spe Puerto P	cify Yes or No- lican, etc.)		e - America k, White, e	tc.	
altimore, Maryland 21215-0036	nin 72 hou n "natura Aedical E	Completed	15. Decedent's Educati (Specify only highest grade co	on	16a. Deced	dent's Usual kind of work DO NOT use	done du		of workir	ng ,		16b. Kind of Business/Industry United States		
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land	uld be fill Mental Hi rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Eddie Turner							inable	. Maiden Surnan e	1e)		
Jary	2 shour and N is ma	Ü	19a. Informant's Name/Relationship (Type.								er, City or Town,			
e,	Health Health tem 27 other tra		Shirley M. Turne. 20a. Method of Disposition		b. Place of Dispo	sition (Name	of	-		nnapo.	lis, Mo			
ē	Pages nent of I ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetery, cren Marylan	natory`or othe	er place,		5-10				Le, Md.	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	100483							uary, l s, Md.		01	
		or J	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the duse on each line.	leath. Do not ente	er the mode	of dying	, such as c	cardiac o	r respiratory ar	rrest,		Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Schemi Due to (or as a con		oke							Onset and Death	
8760,	certificate be executed ding physician and use as the burial-fransit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Interviolation Due to (or as a consequence of): C. Due to (or as a consequence of):											
Box 6	certific ding p	Physician/Med	in the past 12 months?	f yes, outcome of pre	Fetal death 3	Ectopic pred Other (spec					23d. Dat	e of deliver	y Day Year	
ds, P.O	v requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contrib	uting to death but not	resulting in the u	nderlying ca	use give	n in Part I.		23e. Did to		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown		
Records,	S 8	Completed					· · ·			24a. Was a autop perfor	sy med? c	Were autoporior to condeath?	sy findings available inpletion of cause of	
Vital		Be C	25. Was case referred to medical examiner?						of Death (Check only or		1 103	2 110	
0	Physical this control direction	6	1 ☐ Yes 2 No Hosp 27. Manner of Death 2	ital: 1 inpatient 2 8a. Date of Injury	2 ER/Outpatient		Other:	4 L Nuis			ence 6 Oth			
Sion	death. stor: After y the funer	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work?	s 2 🗆 No			on injury coour	00		
Division of	or A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of injury - A building, etc. (Spe	t home, farm, stre ecify)	et, factory, o	ffice		28	Bf. Location (S City or Town	Street and Numb n, State)	er or Rural	Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of my I On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at estigation, in	the time my opi	, date and nion, death	place, a	nd due to the ed at the time,	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)	
	To the	Me	29b. Signature and title of certifier	. 1	1 5	29c. L	icense r	ıumber			29d. Date signed	(Month, D	ay, Year)	
			rank hyp	1 ten	1/17	D	00	55	30.	5	April	30	2010	
1	1541		30. Name and address of person who could	eted cause of death	(Item 23a) (Type, I	Print)		6	00 N	orth Wo	, lfe St. Ba	Itimore	e, MD, 21287	
	Sta Registr	te	31. Date filed (Month Day, Year) 2010	32 Registrar's Sig	gnature da	W.								

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			For State Registrar	State of M	aryiand /	•		of Heal		vientai Hy	giene Reg. No				
	Physicia	n/	1. Decedent's Name (First, Middle, L							2. Date of De	ath			me of Death	
	Medic		Dorothy S. Thom							May	1 2	2 2010	12	:30 A M	
	Examin	er	4a. Facility Name (if not institution, gi	,					tion of Death		4c. County of Death				
÷ - '	From social		Solomons Nursing 5. Social Security Number 6.	C	e (In yrs. last b	nirthday)	So1o	mons 1 Year If U	Inder 24 Hrs.	8. Date of Bir	th.	Calvert		tate or Foreig	
	Funeral Director		213-38-2219 Usual Residence of Decedent	1 M 2 F	92	Yrs.		Days Ho		(Month, Da August	y, Year)	Co.	untry) yland	tale or Foreign	
	and show	tor	10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Insi	de City Limits	_
	Maryl 28a-f otifie	Director	Maryland St. M	lary's			Lo	vevil1	Le				1 [Yes 2 🖾 N	٥
	th the		10e. Street and Number	- D 1			10f. Zip (^{Code} 2065			10g. Ci	tizen of What Co USA	untry?		
	eath wi	Funeral	40439 Sunnysid	12. Was Decedent B	Ever in U.S.	13. W	Vas Decede			ecify Yes or No- Rican, etc.)		14. Race - Ame	rican India	an,	_
215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No			fy Cuban, Me ! ፟፟⊠ No Sp		Rican, etc.)	- 1	Black, White Specify: B1			
ָהַ הַ	72 hou 1 "nata edica	Completed	15. Decedent's (Specify only highest		-16	(Give k	and of work	Occupation done during	most of work	king	16b. K	(ind of Business	Industry		
717	vithin in interest.		Elementary/Seconday (0-12)	College (1-4 or 5 5 +	i+)	life. DO NOT use retired) Teacher						Educat	ion		
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За	uld be I Ment narke	인	John Inomas Somerville Mary Alber							lberta s	Somm	erville			,
Maryland	2 shorth and 27 is not traum		19a. Informant's Name/Relationship							al Route Numbe ille, MD		r Town, State, Zip c	Code)		
อ์	1 and of Hea item		Joseph Thomas / 20a. Method of Disposition		20b. Place	of Dispos	sition (Name	e of	i, Lovev	Date PID		ocation - City or	Town, Sta	ite	
Ē	Page ment c ant; If ury or		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Queen	of Pea	ace Cem	ner place) netery	May 1	8, 2010	He1	len, Maryl	and.		
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	ensee 		22.	. Name and	Address of F	acility Mat P.0	tingley-G . Box 270	ardin , Lec	ner Funera onardtown,	1 Home MD 2	e, P.A. 0650	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	the death. Do	o not ente	r the mode	of dying, suc	ch as cardiac	or respiratory ar	rest,			ximate al Between	
F	hysician/	or o	Immediate Cause (Final disease or condition as Renal Failure a. Renal Failure											and Death	
	Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):	100								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dileta (or as	CONTRACTOR	of:	nge								_
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9	cate b physi s the b	edic		d											
200	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		eth 3	☐ Ectopic pregnancy				23d. Date of delivery				
. BOX	ne death / the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2/EHNo 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (spe				Month Day Year				
7. Ö	that the	by Pl	Part II. Other significant conditions		ut not resultin	ng in the ur	nderlying ca	ause given in	Part I.			use contribute to			
ds,	equires sen sig ould b	ted	HTN, DIAB	ETES						1 🗆	Yes 2	□ No 3 □ Pi	robably (Unknow	1
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ř	n: The ificate or, pag		25. Was case referred to medical					26 Place of	FDooth /Choo	1 L Yes	2714		2 🗆 N	0	_
VII	ysicia s cert direct	To Be	examiner? 1 ☐ Yes ₽₩o	Hospital:	ent 2 ER/	Outpatien	t 3 🗆 DO	Lou	Death (Chec		dence 6	Other (Spec	ifu)		
5	ng Ph fter thi meral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of inju (Month, Day	ry 28b	o. Time of injury		c. Injury at work?		28d. Describe I					
0	ttendii death. tor: Ai the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	ion			М	1 🗆 Yes	2 🗆 No						_
DIVISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4 Homicide determine	28e. Place of Injubulding, etc		tarm, stre	et, factory,	ory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)				Number,			
	Hospi 24 hou Funer eted fill	ledical	(Check Ž L Medical Exa	nysician: To the best of miner: On the basis of e	xamination and	d/or investi	igation, in m	y opinion, dea	ath occurred a	t the time, date a	and place	, and due to the	cause(s) ar	nd manner stat	ed.
	To the within To the Comp	Σ	29b. Signature and title of certifier	dise Fractioner. To the	Dest of my kild	Jwiedge, d	00-	. :			he cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)				
			1085 md					1585	572	-	me	ay 14;	20/0	0	
me			30. Name and address of person who	o completed cause of d	eath (Item 23a	a) (Type, Pr	rint)	#20	Oin.	Freder	i da la	2000	1/4	0	
	Stat	e	31. Date filed (Month, Day, Year)	32. registra	ar's Signature	PIJELL	na	510	rmice	reall	YCR	(101) L	UPI	2	_
	Registra		MAY 14	2010 Buen	a A	h	uld								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2010 TUNIS 2:12F M FLOYD н. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Months Hours Min. Yrs. Director NEW JERSEY 302-30-6079 6, 1937 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f sho 1 Yes 2 No Director MARYLAND WORCESTER OCEAN PINES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA by Funeral 72 MARTINIQUE CIRCLE 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: 1958— DOD, 4/30/10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 3 Widowed 4 Divorced WHITE 1958-62 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN INSURANCE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WHALEN FLOYD Η. TUNIS SR. MARGARET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 72 MARTINIQUE CIRCLE, OCEAN PINES, MD 21811 LILY V. TUNIS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 5/5/10 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO1343 HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter IV. disease, or contribute that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in tailure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EVENCE **Physician** /Medical Due to (or as a consequence of): Examiner muso cy oc Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): CENTEX burial-tra Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Tunis, Floyd H. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/☐ER/Outpatient 3 ☐ DOA Certification: To After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred of or Attending Fath. 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO OCEMACITY 5MMEDA MO

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:30 PM 30,2010 THOMAS MILDRED J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PLATA CIVISTA MEDICAL CENTER CHARLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 5, 1928 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Washington, D.C. Months Days Hours Min. 1 □ M 2 1 F 579-34-1164 82 Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince Georges Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20640 3350 Montrose Rd. United States 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2♣ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 **Black** If Yes, Give Year or Dates 1 □Yes 2 No Completed by 3 ☐ Widowed 4 🗓 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Sales Clerk Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Johnson Thelma Greene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 27 Antoinette Blassingame, 3350 Montrose Rd. Indian Head, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of i Important: If ite any injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5/7/2010 Mt. Olivet Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alexander S. Pope, P.A. 2617 Pennsylvania 2020 Washington, D.C. 2002 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi NEVMON and to (or as a consequence of) physician a the burial-The law requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No atter for u 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an page 2 s autopsy perforn After this certificate 2 No 1 □Yes Hospital or Attending Physiclan: 25. Was case referre to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 V Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

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Registrar

29b. Sigr

SONY CHUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHON CENNA MEDICALCENTER 7C POST OFFICE RD, WALDORF 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ William Voltz, Jr. 2010 21:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 28 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Days Months Hours Min. Country) 217-44-9876 Yrs Director 66 Dec Pennsylvania Usual Residence of Decedent 28a-f show 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Derwood 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17813 Vinyard Lane 20855 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1963— 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify. If Yes, Give White Specify Completed 3 Widowed 4 Divorced 1966 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secret Service U. S. Government 4 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Voltz Madeleine Sloan Η. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is Francine Corbett-Voltz / Wife 17813 Vinyard Lane, Derwood, Md. 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 5/3/10 Alexandria, Signature of Funeral Service Licen 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 Box 5038, Laytonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending place as SB IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Day ed by the a g 🗌 Unknown P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ₹ No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pendina death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the it 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

State Registrar SHYED E 31. Date filed (Month, Day, Year)

Year) 32. Registrar's Signature

AD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Jacks

		For State	i icas	e Type or Pr State of N		d / Depa	artment of H	lealth and l			-	•
		Registrar 1. Decedent's Name	e (First Middle I	ast)		Cer	tificate of L	Jeath	2. Date of De	Reg. N	2010	15884
Physicia Medic		Rose		Wingo					Month May		2010 Year	3. Time of Death 7:35 A ^M
Examin			. 0	ve street and number)				Location of Death		40	County of Dea	th
Funeral		5. Social Security N	umber 6.	Sex 7. A		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bit	rth	9. Bir	thplace (State or Foreign
Director ≥		216-28-1 Usual Residence of	075	1 □ M 2 🖾 F	80	Yrs.	Months Days	Hours Min.	31,1	930 Mai	ryland	
th with the Maryland ms 23a or 28a-f show must be notified at.	Funeral Director	10a. State MD	10b. County Anne Ar	rundel		r, Town or Loc Arnold	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
with the is 23a or ust be n	neral D	10e. Street and Nun		nue			10f. Zip Code 2101	2			itizen of What Co USA	ountry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Б	11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed	ied 2 ☐ Ma <i>m</i> ied 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?	H	Vas Decedent of Hi Fyes, specify Cuba	n, Mexican, Puerto		14. Race - Ame Black, Whit Specify:		
nin 72 hou ne. han "nat u e Medica	Completed	(Spe		Education grade completed) College (1-4 or	5+)	(Give F life. D	lent's Usual Occup kind of work done of O NOT use retired)		king		Industry	
ed with Hygier other t	Be C	17 Father's Name /	First Middle Last	4		Hor	nemaker	40.14-11-1-11-1			Home	
uld be file Mental I narked o natic eve	70 E	17. Father's Name (First, Middle, Last) Joseph Vincent Lascola 18. Mother's Name (First, Middle, Maiden Sumame) Nancy Piazza							Sumame)			
nd 2 shouealth and m 27 is mer traum			a Peddio	(Type, Print) cord /Daugl	nter		g Address (Street a					
Page 1 a nent of H ant: If ite ıry or otf				Removal from Stat	e c	emetery, crem	sition (Name of natory or other place ans Cemet	e) May	05, 010		ocation - City or	
permit. Departn Importa any inju		21. Signature of Fur	neral Service Lice	ensee		122 40	Name and Address PS GOV. R	SOOS P	-A Sev	erna	Park Fi	uneral Home
Olassiais s./		23a. Part 1. Enter t shock, or hear Immediate Cause (rt failure. List only	implications that cause one cause on each li	ed the death	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory a			Approximate Interval Between
Physician/ Medical Examiner		disease or conditio resulting in death)		Due to (or as	a consequ		chal	Cur	U-			Onset and Death
p #	iner	Sequentially list co if any, leading to im cause. Enter Under	nmediate	b. Due to (or as	a consequ	ence of):			···			<u> </u>
executer an and rial-trans	I Examiner	Cause (Disease or that initiated events resulting in death) I	S	C. Due to (or as	a consequ	ence of):						
icate be g physici s the bu	ledica		,	d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yes 2 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						у			23d. Date of de Month	livery Day Year
requires that the de been signed by the should be detached		Part II. Other signif	icant conditions	contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t			o the cause of death?
he law req te has bee age 2 shoi	Completed							***************************************		psy ormed?	prior to death?	topsy findings available completion of cause of
ian: T intifica ctor, p	Be C	25. Was case referre	ed to medical				26. Pla	ace of Death (Chec	1 L Yes	2	o 1 ∐ Yes	s 2 U No
Physic this ce al dire	၉	1 🗆 Yes 2 🕏	No			ER/Outpatien	t 3 DOA Othe	er: 4 Nursing H	ome 5 🗆 Resi	dence (6 Other (Spec	ify)
ending Feath.	Certificate:	27. Manner of Death Natural 2 Accident	5 Pending Investigati		ury ay, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe I	now injur	y occurred	
al or Attendi s after death. Il Director: A ed in by the fu		3 ∐ Suicide 4 □ Homicide	6 ☐ Could not determine	28e. Place of Ir	jury - At ho tc. (Specify)		et, factory, office		28f. Location (City or Tov			ral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of urse Practioner: To th	examination	and/or invest	igation, in my opinic	n, death occurred a	at the time, date a	and place	e, and due to the	cause(s) and manner stated
To the within to the comp	~		title of certifier	حسر			29c. License	number		29d. Da	ite signed (Monti	h, Day, Year)
45		30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Type, P		mine	Clert	Z-	MA	1618
Stat Registra		31. Date filed (Month	MAY 05		rar's Signat	ure	had I	, (330				• • •
riegistra	211			- COLO		19.19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 5885 Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Alvie Leroy Weller May 3, 2010 1559 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1**X**M 2□ F Months Days Hours 214-14-6721 88 June 10, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐Yes 2 No Maryland Carroll Union Bridge 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 876 Banner Avenue 21791 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Yes, Give Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Dairy Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Edward Weller Fannie Belle Rowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Weller, wife 876 Banner Avenue, Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Grd 5/7/2010 Finksburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 29a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Due to (or as a consequence of): ZOYEARS DIABETES MELLITUS - ADULT Esque many list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 🗌 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mcdical Eventine profilled at once.

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

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Be Completed

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Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the particular of the contraction.

Division of Vital Records, P.O. Box 68760,

Part II. Other signif	ficant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown				
					24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical				26. Place of De	eath (Check only one)					
examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Deat 17—Natural 2 Accident	h 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only		nysician: To the best of my kno niner: On the basis of examina				and manner as stated. I place, and due to the cause(s)				

29c. License number 10014317

WIL 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM INTHICUM, M.D.

ONE KINGS DRIVE, TADEYTOWN, MD 21787

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

MAY 05

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylan		rtificate of		-	Glene Reg. No.	010	15886	
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	3. Time of Death	
The same	/Medio		George Alberta. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	May 2,		4c. County of Death		
			131 West Main Str		land hinth down	Westm:	inster If Under 24 Hrs.	Carro				
	Funeral Director		5. Social Security Number 218-74-4401 Usual Residence of Decedent	7. Age (In yrs. 51	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Feb 9,	ı <i>y</i> , Yea <i>r)</i>	Cou	place (State or Foreign intry) nsylvania	
	yland how		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits	
	8a-fs	ector	Maryland Carro	11			stminste	c 			1 Yes 2 □ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show myn finury or other traumatic event, it a l'edical Examitation in the cofficial and page.	Funeral Director	131 West Main Str	eet		10f. Zip Code	21157			en of What Cou USA	ntry?	
	ter de	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No	S. 13.	Was Decedent of H f Yes, specify Cuba	łispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14	 Race - Ameri Black, White, 		
036	ours af		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2XX No	Specify:		5	Specify: who	ite	
Maryland 21215-0036	n 72 h "natu edical	Completed by	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor	rking	16b. Kind	d of Business/Ir	ndustry	
212	d withingiene.)omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Mechanic	2)		Αι	utomobil	les	
pu	be file tal Hy d othe event,	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle Marie Th		urname)		
ryla	Should be filed within and Mental Hygiene. Is marked other than aumatic event, In M.	은	Vernon Eugene W		10b Moilir	ng Address (Street				Town State 7	in Codol	
	1 and 2 s Health an tem 27 is i		Joshua R. Wagner,	· ·		West Main						
Baltimore,	ges 1 and of the lift frem or other		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □	20b. F Removal from State	Place of Dispo	sition (Name of matory or other place	ce)	Date		ation - City or T		
Itim	permit. Pages 1 Department of F Important: If Ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License) <u>C</u>	arroll	Cremator 2. Name and Addre	y 15/6/			field,		
Ba	Depar Impor any ir		- Ljusti R. I	Caronalue		91 Willis	1.1	yers-Du Westmir	nster	, MD 21	157	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			CANO	ER				Onset and Death	
	Examiner			Due to (or as a conseq	uence of):							
	cuted od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
68760,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):							
68	ertifica ing ph	Medical	IF FEMALE:									
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 9 ☐ Unknown	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	ey .		23	d. Date of delivery Month Day Year		
σ,	that the		Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?	
ords	w requires s been sign should be	ted by						10	Yes 2	No 3□ Pro	obably 4 ☐ Unknown	
Records,	e law re has be e 2 she	Completed						24a. Was	psy	prior to c	copsy findings available completion of cause of	
Vital F	ician; The certificate h ector, page		25. Was case referred to medical					1 □ Yes	2 No	death? 1 ☐ Yes	2 □No	
ί	lysicia lis cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	26. Place of Dea ler: 4 ☐ Nursing H	tome 5 Res		□Other (Spec	ify)	
	ing After		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o	Wor	ry at k?	28d. Describe				
Division	deatl ctor: / the	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, str		lYes 2 □No	28f. Location /	Street and	Number or But	ral Route Number,	
Ö	ital or its after al Dire	Certification:	4 nornicide	building, etc. (Specia	fy)			City or To	wn, State)		8	
	To the Hospital or A within 24 hours after To the Funeral Directory Completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physical Example Control on the control of the control on the con	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	るができ	M	29b. Signature and title of certifier	Jay MD		29c. Licens	5955	2	51	signed (Month)		
	7		30. Name and address of person who	ompleted cause of death (Iter	n 23a) (Type,	Print)	A PUL	= An	1000	/		
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrac's Signa	ature	1 /W	y proc	e o	143	mins	1358 MUZIST	
	Registi			2010 Genera	A. 1	bake						
DHI	MH 17 Rev 1/2	001			17	2 4 2 2 2						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Milton Wolcott May 5, 2010 3:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 XM 2 □ F Director 579-38-4712 85 Washington, DC Jan 2, 1925 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov event, the Medical Examiner must be notified at Director 1 Yes 2 □ No DC Washington 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? ö or items 23a 1718 P Street, NW #617 by Funeral 20036 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Tyes 2 No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced "natural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other the any Injury or other traumatic event, Italy once. Printing Press Operator Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Wolcott Marthena Whipple 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Blandamer/sister 602 E. Lynfield Drive Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 5/7/2010 4 Donation 5 Dother (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 uarita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) NO /Medical Due to (or as a consequence of): Examiner Aphavia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Wernickey nuphalo that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 2 NO 1 ☐ Yes Director: After this cerund in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD D67814 5/10 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar FRANCISCA

31. Date filed (Month, Day, Year)

BRUNEY

29449 CHARLOTTE HALL RO

32. Begistrar's Signature

CHARLOTTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	for State Of IVIA State Registrar		artment of Health : rtificate of Death	and ivie	ental Hyglei Reg.	2010	15888	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			- 2	2. Date of Death		3. Time of Death	
	Medic Examin	al	Wellington Waters, 4a. Facility Name (if not institution, give street and number)	Jr.	4b. City, Town, or Location of	of Death	April 26	2010 Year 4c. County of Deat	9:30 A ^M	
	LAdillill	CI	7854 Jacobs Drive		Greenbel				George's	
	Funeral Director		578-70-5085 ^{1 ⊠ M 2 □ F}	(In yrs. last birthday) 58 Yrs.	If Under 1 Year If Under Months Days Hours	Min.	B. Date of Birth (Month, Day, Yea OV 13,	9. Bird 1951	thplace (State or Foreign untry) DC	
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo-	cation				10d. Inside City Limits	
	Maryl 28a-f notified	Director	Maryland Prince George's			reenbe	1t		1 🏿 Yes 2 🗌 No	
	vith the 23a or st be r	ral	10e. Street and Number 7854 Jacobs Drive		10f. Zip Code 20770		10g.	Citizen of What Co		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 □ Never Married 2 🏋 Married 1.□ Yes 2 🛣 N	do.	Was Decedent of Hispanic Original fyes, specify Cuban, Mexican □ Yes 2 ♣ No Specify:	igin? (Specif n, Puerto Rid	fy Yes or No- can, etc.)	United States 14. Race - American Indian, Black, White, etc. Specific Black		
Ş	hours a	leted	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education		dent's Usual Occupation		161	Specify: BLACK D. Kind of Business Industry		
212	hin 72 ne. than "r te Med	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	(Give i	kind of work done during most O NOT use retired)		100		mployed	
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ylan	ld be fi Mental arked atic ev	욘	Wellington Waters, Sr.	•				n VanDros	s	
, Maryland 21215-0036	d 2 shou alth and a 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Janice T. Waters/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 7854 Jacobs Drive Greenbelt, Maryland							
Baltimore,	ge 1 an nt of He :: If item or othe		20a. Method of Disposition 1 □ Burial 2 🏝 Cremation 3 □ Removal from State	1 2	natory or other place)	Dat Mav		. Location - City or		
altın	permit. Page 1:8 Department of H Important: If its any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Unerse	-	Crematory . Name and Address of Facility	May 2010 y Ste	wart Fun	Clinton, eral Home		
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	scuted and transit	Examiner	Cause. Clire of orderlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of):							
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۵/۵ ۵	tificate ng phy as the	Med	IF FEMALE:		1 5-					
. Box 68/60	ne death ce	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 2sc. If yes, outcome of 1 Live Birth 2 1 Yes 2 No 9 Unknown	! ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
л. О	s that thighed by be detail	by	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part I	I.			the cause of death?	
ecords,	require been si should	leted	***************************************				1 L Yes		obably 4 Unknown	
Hecc	The law sate has page 2 t	Completed					autopsy performed 1 Yes 2	prior to death?	opsy findings available completion of cause of	
VITAII K	ician; certific ector,	Be	25. Was case referred to medical examiner?		26. Place of Deat	th (Check or				
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DIVISION OF	ital or Att urs after d ral Direct lled in by		4 Homicide determined 25e. Place of Injury building, etc.				City or Town, Sta	· · ·		
Company of the control of the contro							ice, and due to the c	ause(s) and manner stated.		
	5		Mattloba H. So M. 30. Name and address of person who completed cause of dea	<u> </u>	D26250			May 4.	7010	
	Z,		Matilda H So 1221 Margant	dia Tama T		d 20	774			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	,					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month_ 5 Physician/ 2010 Betty Jean Watson May 11:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George Clinton Southern Maryland Hospital Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 M 2 K F Months Days Hours Min 9/1/1925 ear) 070-24-4904 84 Director Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Temple Hills Marvland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5601 Kenwood St. 20748 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)

Output

Description: 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Hostess Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Change Lucien Laura Isenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Jadir/Daughter 5601 Kenwood St., Temple Hills.MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatiop 5 ☐ Other (Specify) Resurrection Cemetery 5/10/2010 Clinton, Maryland of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature 6160 Oxon Hill Rd. Ōxon Hill, MD 20745 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. P 1. Enter the disease or complicati Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or illijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number

Registrar
DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print)

10-03361 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lefrankal Devon Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month **Medical Examiner** 0257 hrs May 2, 2010 Lefrankal Devon Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5320 Marlboro Pike District Heights Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** Months Days Director Hours $_{1}X_{M}$ 579-04-1935 2 F 29 Country' 26 1980 DC Usual Residence of Decedent Ę 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No or items 23a or 28a-f shormust be notified at once. altimore, MD 21215-0036

mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
prorant: If item 27 is marked other than "natural", or items 23s or 28s-f sho proventy if or other reamatic event, the Medical Examiner must be notified at once. Maryland Prince George's Upper Marlboro 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10115 Running Brook Lane 20772 United States 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married White, etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year Specify: Black Yes 2 X No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) llth none none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Frederick L. Edwards Janet Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick Edwards/ Father 2717 Iverson Street Temple Hills, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 11, Suitland, Maryland Washington National 2010 Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Ser Inc. 4001 Benning Rd. NE Washington, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Year Day 2 past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? page Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot Natural FOUND: Pending 1 ✓ Yes 2 No the May 2, 2010 0245 hrs 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Certifi Suicide or Town, State) 5320 Marlboro Pike, District Heights, MD determined (Specify) Parking Lot 4 🗸 Homicide 29a. Certifier completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2010

State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

DOME

Laron Locke MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's 6ignature

ORIGINAL

Dark

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year PATRICK). ZISKA A 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALUNDEL ANNAPOLIS ANNE MEDICAL CENTER ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 8-28-1930 1 ₺ M 2 🗆 F Days Hours Min. 282-24-7148 79 Director Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Prince Georges Bowie 1 Pyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4018 Wharton Turn 20715 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Writer Speech Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Henry Ziska Anna Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wharton Turn Bowie, Md. 20715 Brian D. Ziska 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/5/2010 Glen Burnie Atlantic Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEP SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami (Disease or imjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed death? certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 Yes 2 🗀 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: Tofthe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Capstac

31. Date filed (Month, Day Year)

MAY 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Larry May Douglas Anderson 11:55PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yu
Sept. 15 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 375-54-6145 62 Director 1947 MI Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7710 Harmans Road 21076 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fredrick Anderson Grace Northcott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Shirley A. Anderson / Wife 7710 Harmans Road Hanover, Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral & Cremation fulle MO1580 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician O Ca disease or condition Medical resulting in death) Examiner tears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examine Hospital or Attending Physician: The law equires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): **reral Director:** After this certificate has then signed by the attending physician filled in by the funeral director, $p_{\rm s}ge$ 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 <a>D Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 MER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury death. Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ٩ 52894 17 5 10

State Registrar egistrar's Signatu

timore, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 655 W. Ballings St. Ball

amend #Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State of Maryland / Department of Health and Mental Hygiene

1 - Registrar Certificate of Death

Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year POIC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 218-56-0817 Funeral Country) Maryland Months Days Hours Min. (Month, Day, Nov 24, Year) . 1952 1 □ M 2 ⋤ F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore Baltimore City** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21229 840 Allendale Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mildred Burgess Frank Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Baltimore Avenue, SW Glen Burnie, Maryland 21061 Erica Garts 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Brooklyn Park, Md 04/07/10 4 Donation 5 Other (Specify) Cedar Hill Cemetery & Mauscleum 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that quised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊕nysician/ Due to (or a a consequence of) disease or condition resulting in death) Medical Examiner Gastrointestinal Bleeding CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Oue to for se a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 2 🗶 No 1 Yes 2 2 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 T Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 × No 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 IV ပ္ 1
Inpatient 2 □ ER/Outpatient 3 □ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101241833 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 5+ Baltmore m) 12anne Greene VR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Meze SR. BOOTH 0. LESTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F nth, Day, Months Days Hours Min Yrs 1923 PENNSYLVANIA **Director** 87 579-16-9066 JAN Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 4301 KINMOUNT ROAD permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 No NAVY Black, White, etc. Completed by 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes, Give BLACK Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT REPRODUCTION FOREMAN 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MOORE SADIE Ε. OLIVER B. BOOTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 KINMOUNT ROAD LANHAM, MARYLAND 20706 KATIE C. BOOTH/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 5/27/2010 CHELTENHAM, MARYLAND e of Funeral Service Licensee Signatu 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of). resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 9 Unknown signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 shoul peer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law has autopsy performe 24 hours after death.

Funeral Director; After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 N Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 22/1/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Lucle Rd = 305 Lankan MD THOMAS 0 31. Date filed (Month, Day Regi rar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bonds Audrey Yvonne 2010 1:12 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto Gilchrist Hospice Towson Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🎛 F Months Hours Min. Month, 28-1936 Director 73 N.Y. 128-26-1026 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N.Y. NEW YORK 1 XYes 2 No na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10026 U S 117 Street Α 210 W. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important! If item 27; marked other than "natural", or any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Black Specify: Completed 3 🔀 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Bonds Taylor Lillie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1702 N. Washington Street Balto, MD 21213 Yvonne Wade-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oakland Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State 5-27-2010 Yonkers, N.Y. 4 Donation 5 Other (Specify) Signature of Mineral Service Vicensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cana un a disease or condition / Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury s after death. 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 only one) 29b. Signature and title of certifier R149194 May 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IV. Charles Marian Grant 6701 21204 WD Towson 31. Date filed (Month, 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Benjamin Burns 5/1ďÿ10 12:45pm M Medical 4a. Facility Name (if not institution, give street and number)
1336 Towson Street Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F (Month, Day, Year) 2/2/1945 216-42-5207 65 Months Davs Hours Director Usual Residence of Decedent or 28a-f show e notified at should be filed within 72 hours after death with the Manyland nand Mental Hyglene. 'r is marked other than "natural", or items 23a or 28a-f shor is marked other than "natural", or items 25a or 28a-f shor are mattle event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1336 Towson Street Funeral 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced white 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Longshoreman Shipping Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin F. Burns 19a. Informant's Name/Relationship (Type, Print)

Cora Elizabeth Burns /Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 1418 Cooksie Street, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery Date 20c. Location - City or Town, State # Burial 2 ☐ Cremation 3 ☐ Removal from State 5/14/10 Baltimore Maryland 4 Donation 5 Other (Specify) which Libersee Victor P. Charles Common The Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Sico 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Petween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran the attending physician and that initiated events Due o (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) Pregnant at time of death 9 | Unknown g Unknown signed by the P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOSCIL-ROTTE Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Funeral Director: After this certificate has eted filled in by the funeral director, page 2 s 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗌 No s after death Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examined ion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within To the 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pata lughu Swite 6 Brook YN MO chriss 3721 ee St

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULINSKI 539 M 2010 Medical 4a. Facility Name (if not institution, give street and number) City. Town, or Location of Death 4c. County of Death **Examiner** trundel Gen 20113 NNA Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 055-28-9857 1**√**M 2 □ F Months Hours Min Marth 23/1935 74 **Director** NY Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director NY Erie Williamsville XX Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 62 Noel Drive 14221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes XX No Specify: If Yes, Give Year or Dates white Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NY State Thruway Auth. Toll Collecter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Bulinski Agnes Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Bulinski / Wife 62 Noel Drive, Williamsville NY 14221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Sheridan Park Crematory 5/14/10 1 Burial 2 Cremation 3 Removal from State Tonawanda, 4 Donation 5 Other (Specify) Funer Service Licensee Victor Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final rterioselerotic Onset and Death Ph_sician/ 158 A5 2 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner demi Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. • Funeral Director; After this certificate has performe 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 2 🗆 No Other: မြ 1 X Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Investigation injury Natural 1 Tes 2 No Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Deput

V

State Registrar Name and address of person who complete

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DNES

10-03578 Timothy Dean B			r pe or Print in State of Marylan		t of Health				egib Reg. No	20	Control of the Contro	1589
Physicia Medical Exami	ın/	Decedent's Name (First, Mideline Timothy		urnett				2. Date of D Month May 9, 2	eath Day			3. Time of Death 1215 hrs
		4a. Facility Name (if not instituti 10870 Crain Highway		ber)	4b. City, Too		ocation of Death			4c. County of Charles	Death	-
Funeral Director		5 Social Security Number 251-33-6249	6. Sex 7.	Age (In yrs. last birthda	y) If Under Months	1 Year Days	If Under 24Hrs Hours Min.	-	Birth(MM	и/DD/YYYY) 76	9. Birth Foreign Cour	
nd show any <u>ce.</u>	Ļ	Usual Residence of Decedent 10a. State 10b. County SC OC	conee	10c. City, Town or L	ocation air Play						T	10d. Inside City Limits
n the Maryla 3a or 28a-f s	Director	10e. Street and Number 1272 Tugalo	o Heights		10f. Zip C	ode	296	43	10g. C	itizen of Wha	at Countr	usa
ter death with	Funeral		Married Armed Ford 1 Yes ivorced If Yes, Give Year	dent Ever in U.S. 13	. Was Decedent If Yes, specify (Cuban, I	Mexican, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - White, Specify:	etc.	an Indian, Black, white
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ompleted by	15. Decedent's Education (Sp Elementary/Secondary (0-12 12	or Dates: ecify only highest grade	durii	edent's Usual Oc ng most of workir Mechanic	cupation	n (Give kind of w	ed)	16b.	Kind of Bus		dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be Con	17. Father's Name (First, Middle Timothy	Burnett, Sr			18	Mother's Name. Phyl			n Surname) reeman	L	
MD 21 d 2 should Ith and Mer n 27 is man sumatic ev	٤		iship (Type, Print) irnett, Sr.	/Father 12	ailing Address 268 Tuga	1∞	Heights	Circl	.e, 1	Fair P	lay	SC 29643
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other S 21. Sign Sure Fun rai Service	Specify:	Gracel	or other place) and Wes	t Ce	metery	5/16,	/10		reen	own, State
		UIW~	00	_	²² Name and As 1501 Ea							1230
Physician /Medical Examiner		23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line.	intoxicatio				respiratory a	arrest, sh	nock, or hear	1	Approximate Interva Between Onset and Death
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co									
ecuted and	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):								
ਭ ਛ ਫ	edical	X UNPENDED	AMENDED 238	a,27, 28a-f	, per ME	E G90	03 5/24/	/10 TT				~
Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be executed tours after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be deached for use as the burial - transit	siciar	IF FEMALE: 23b. Was decedent pregnant in least 12 months? 1 Yes 2 No 9 Ur	the 1 Live birth	t at time of death 5	Fetal death Other (Specify	3	Ectopic pregnal		23	3d. Date of d Month	elivery Dag	y Year
S, P.O. E uires that the n signed by the Id be detached	ed by Phy	Part II. Other significant condi	itions contributing to d	eath but not resulting in	the underlying ca	ause give	en in Part I.	1 🗌 Y	'es 2[No 3	Probat	e cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that trs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace	Completed							per 1 ✓ Yes	opsy formed?	pri de		psy findings available npletion of cause of 2 No
Vital hysician: this certifi	To Be	25. Was case referred to medical examiner?1 ✓ Yes 2 No	Olempital, com	atient 2 ER/Outpa			Death (Check of her Mursing		Resid	lence 6 🗸	Other: S	Scene
on of canding Planth.			28a. Date of (Month, Date of (Month, Date of (Month, Date of (Month, Date of (Month))	ay,Year)	1		rives .	28d. Describ unk	e how in	jury occurred	d	
Division of spital or Attending I hours after death.	Certification:	3 Suicide 6 X Cou	Joungarion	of Injury - At home, farm, hotel/m	street, factory, of	fice buil		or Town,	State)			Route Number, City

Divisi
To the Hospital or Att
within 24 hours after de
To the Funeral Direct
completely filled in by

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD 31. Date filed (Month, Day, Year) State

Medical (

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

Assistant Medical Examiner

OCME

ORIGINAL

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 10, 2010

Registrar

0-03611 harles M. Berg	gholt	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
		1- For State Reg. No. 2010 589
Physic Nedical Exam		Charles M. Doweholte
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore 4c. County of Death
Funeral Director		5. Social Security Number 175-36-7229 6. Sex Number 6. Sex Number 7. Age (In yrs. last birthday) Number 175-36-7229 7. Age (In yrs. last birthday) Number Nu
Maryland 28a-f show any d at once.	٥	Usual Residence of Decedent 10a. State
the Maryl ia or 28a-i	Director	10e. Street and Number 3135 Bogle Road 19020 10g. Citizen of What Country? USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiens. If then 72 hours after death with the Maryland Important: If litems 73 a narked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Polyages 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Page - American Indian, Black, White, etc.
p, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiest free "natural"; tem 27 is marked ofter than "natural"; traumatic event, the Medical Examiner traumatic event, the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver 16b. Kind of Business/Industry Towing/Auto
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Charles M. Bergholtz, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Catherine Derr
MD 21; d 2 should b Ith and Men n 27 is mar	Tol	19a. Informant's Name/Relationship (Type, Print) Carol Bergholtz / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3135 Bogle Rd, Bensalem PA 19020
Baltimore, permit. Pages I am Department of Heal Important: It iten injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation XX Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, or other place) St. Valentine S Cem. 20c. Location - City or Town, State 5/15/10 Bensalem PA
Balt permit. Depart Import injury		21 Signature of Funeral Service Licensee Victor P. Doda 22 Name and Address of Facility Charles I. Stevens Funeral Home, Inc. 21230
Physician /Medical Examiner	miner	23a. Part I. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Due to (or as a consequence of):
vecuted and ransit	al Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
v 6 2 2		X UNPENDED 23a,27,permE, g904 6/7/10 TT
Sox 68' leath certifi e attending for use as	Physician/Medi	FFEMALE: 23c. If yes, outcome of pregnancy 1 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
, P.O. E	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law require and after death. In Director: After this certificate has been si led in by the funeral director, page 2 should b	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital ysician: his certif	o Be	25. Was case referred to medical examiner? 1 Ver 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Other Other:
ion of \text{tending Phy} eath. ter After the funeral of the fune		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Divisi pital or Att ours after de eral Directe	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Ž	29b. Dignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 11, 2010
ϕ		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis		31. Date filed (Mogth, Day, Year) AAY 2 I 2010 32. Registrar's Signature A. Jankel

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 4 Registrar amend per KH 9903 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** NICOLE 2010 0555 AM PRIL /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MOSPITAL Baltimore If Under 1 Year | If Un 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 X F Yrs Director PRIL MAR IANO Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRANCH KOBERT LAMONT TIARA COLE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tiffany Tiara Cole/mother 2457 Bainesley Place; Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signature of Funeral Servi $^{22.\,\text{Name and Address of Facility}}_{\text{State}}$ Board; 655 W. Baltimore Street . Wade Director Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Luse (Final SEVERE PREMATURIT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

Director: After this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 J. HANOVER ST. BALTIMME POETANA 31. Date filed (Month, Day, Year) NAY 2 12 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	1	State Registrar					Cei	rtifica	te of L	Death)		R	eg. No.	0.1	0	159)
Physician		1. Decedent's Name (First, Midd	le, Last)										te of Dea		Y	ear	3. Time of Dea	
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Examiner	1	4a. Facility Name (If not institution 240 Powdersby	_		ımber)			_	r, Town, or Oppa	Location	of Death				unty of			
Funeral		5. Social Security Number	6. Sex		7. Age (/	n yrs. last b	oirthday)	If Und	r 1 Year		r 24 Hrs.	8. Da	te of Birth	1	9	. Birthplac	e (State or Fo.	eig
Director	H	219-38-3293	1 🗆 N	1 2 ℃ F		69	Yrs.	Months	Days	Hours	Min.	Nov	onth, Day	, ^{Year} 194	0 1	Maryl	and	
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cian	1	Immediate Cause (Final disease or condition	_ a.			b	(en	7	LU	nier							risei and Deali	'
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completely filled in by the funeral director, page 2 should be detached for u	1	29b. Signature and title of certific	er	and fildf	mici state(4.		2	9c. Licens	e number			2	29d. Date s	signed (/	Month, Da	ıy, Year)	
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	-	30. Name and address of person	who com	pleted cau	se of deat	h (Item 23a	a) (Type.	Print)										_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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AMEND ITEM#9, perFH, G903, 5/26/2010, WS

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Valentine Joseph Biemer Month Year 12 39 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FAAnklin Square Hospital Center rosedale Baltimore 6. Sex 1 **X** M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 12, Year 29 Months Hours Min. Kansas New York Director 80 213-26-9016 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🗓 No White Marsh Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21162 9700 Winkler Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. Completed by 21215-0036 If Yes, Give Year or Dates 1952-1954 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 Divorced 4 Divorced 15 Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Accountant SIEW Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Rosanna Feil Valentine M. Biemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Winkler Street White Marsh, Md. 21162 Spouse Jovita Biemer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5-21-2010 Balto. Md. Bayview 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home 21236 Nottingham, Md. 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death P Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner AsbesTosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardiomyopathy congestive Heart Failure Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? artery diseas 24a Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ___ Natural
__ Accident
__ Suict 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practicer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21846 -19-2010 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J DR Martin 9000 FRANKLIN SQUARE DR BOLTO Md Sheridan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 21 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis A. W. Bennett May 19,2010 9:42P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Balto. Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Numbe 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Months Days January Year, 1934 Maryland Director 213-30-3140 Yrs 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Md. Balto. Perry Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9913 Fox Hill Road 21128 IISA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1954-1956 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ဂ္ William Bennett Mary Ann Stotsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine H. Bennett Spouse 9913 Fox Hill Road Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery! 5-24-2010 4 ☐ Donation 5 ☐ Other (Specify) Fullerton, Md. 21. Signature of Funeral Service Idensee 22. Name and Address of Facility Schimunek Funeral HOme 1 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ iolon Canar disease or condition resulting in death) Mens Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 L 9 Unknown ate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has I autopsy performed? Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ျှ 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 NOther (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After I completed filled in by the funer. 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide
Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency in strategies of the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) CRNP RIUTITY 20,2010 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Towson

21204

H Charles

32. Registrar's Signature

Grant

lar an

31. Date filed (Month, Day, Year)

6701

10-03710 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jerome Clayton Booze 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 14, 2010 1330 hrs **Medical Examiner** Jerome 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 3313 Paton Avenue **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian Days Hours Director 1 M Country) 2 F Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits any 10a State 10b County Kaltimore 1 Xes 2 No or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5208 ä mex Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other them. 21215-0036 astruction 17. Father's Name (First, Middle, Last Be Jerome av 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. randnotker 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, grematory or ot er place 1 Surial 2 Cremation 3 Removal from State Saltimore 4 Donation 5 Other Specify Signature of Funeral Service License well unura Heig Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one cause on each line Between Onset and Me die if Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and i be detached for use as the bunal - transi sician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Month Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phys 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O. Š 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si, ; page 2 should by Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed?

✓ Yes 2 No death? 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 V Yes 28a. Date of Injury FOUND: After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject shot FOUND Natural 1 Yes 2 ✓ No Pending the May 14, 2010 1310 hrs Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3313 Paton Avenue, Baltimore, MD (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's anature

(Mest)

Ana Rubio MD

31. Date filed (Month, Day, Year,

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Terry Lee Burton, Sr. 7:38 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St. Agnes Hospital N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 X M 2 □ F Months Days Hours Min. 54 217-58-1627 Director Jul. 20, 1955 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 X No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4103 Oak Road 21227 United States Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 X No 1 Never Married 2 Married altimore, Maryland 212 5-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore County College (1-4or 5+) Fireman Fire Department Health and Mental Hygidem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Burton, Sr. Frances O. Knickman ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once. Susan Burton - Wife 4103 Oak Road, Baltimore, MD 21227 20b. Place of Disposition (Name of camelery, crapatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Memorial Park 5-20-2010 Glen Burnie, MD Name and Address of Facility Ambrose Funeral Home of Lansdown 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician iovasular earc disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | performed 1 □ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manno of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 | Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifie

Mason 5 Tonya 900 31. Date filed (Month) Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Caton

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 056418

Ave Baltimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mar. 2, 1 X M 2 □ F Months Days Hours 217-40-1974 Maryland Director 67 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. It ant. If Item 27 is marked outher than "natural", or items 23a or 23a-f show jury or other traunatic event, the Madical Examiner must be notified at. jury or order traunatic event, the Madical Examiner must be notified at. 10b. County 10a. State Director 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 515 Gun Road 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Convent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmer Edgar Bezold Jean Audrey Brill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Bezold - Wife 515 Gun Road, Halethorpe, MD 21227 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 □ Burial 2 ဳ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Departon 5 Other (Specify) Atlantic Crematory 5-21-2010 Glen Burnie, MD Sin 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD Part 1. Enter the disease, or complications that caus sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant a Pregnant at time of death Month Day Year 9 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of p

of death (Item 23a) (Type, Print)

3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

Year

1 ☐ Yes 2 No

4:30 A M

2 🗆 No DOVE 4 Nursing Home 5 Residence 6 Other (Specify, 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral D

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, dress of person who completed cause of death (Item 23a) (Type, Print ter Street Washynister, MD01157 State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. -1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bunn 1:29 10 /Medical Facility Name of not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesia Health Cave Ratimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security 7. Age (In yrs. last birthday) Date of Birth (Month/Day, Year) 10/07/1929 **Funeral** 1 XM 2□ F Months Days Hours Min. NC Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show MD Baltimore Director 1 X Yes 2 □ No injury or other traumatic event, the Michael Exercitive cust be notified 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21212 YOrK USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kous Driver Department of Health and Mental Hygie Important: If Item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bunn Raltimore Maruland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Baltimore, Maryland 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 DOther (Specify) any 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: asn (23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No ō Month Day Year 5 Other (specify) ed by the g 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 1 ☐Yes → No or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 20 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manus of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death To the Funeral Director: 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who com pleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 18, 2010 William T. Buckeridge 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Care and Rehabilitation Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Ye 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Michigan **Funeral** 1 X M 2 □ F Hours Min 61 215-52-9591 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19040 Sedley Terrace 20879 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Vietnam White 3 Wildowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Master Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ഉ James William Buckeridge Alice Nelms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Buckeridge/Brother 4605 W. Frankfort Drive, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State May 24 2010 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.,
300 W. Montgomery Avenue, Rockville, Maryland 20850 Willian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year signed by the a Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No Investigation To the Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ، 24 ho.. حدم Funeral F Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Ners Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of c 29c. License number 005757

State Registrar

DHMH 17 Rev 7/2009

10301 Georgia Avenue, #203, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrari

M.D

Ahmed Heshmat,

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene me, g903,05/21/2010dhb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 이 니 Physician/ 0213 10 (ear Michael Cockrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Shock Trauma Ctr. Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 212-56-7891 MD Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore 1 X Yes 2 No MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 33 S. Fulton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 TNo Specify: African-American Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Special Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Emma Richardson Charles Cockrell Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra A. Cockrell-Perry/ Sister 24 Baroness Ct., Owings Mills,MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Veterans 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 5-4-2010 Owings Mills, MD Donation 5 Other (Specify) 21. Sign dure of Funeral Service Licer 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In fratentorial Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Subdural iday hematoma acute CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 7 100 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury **Fournat** Day, Year) **04/23/2010** Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Hatural 5 Pending Probable fall. 2 X Accident 1 Yes 2 No Unknown ^M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 33 S. Fulton Ave. Baltimore, MD determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD427028

Registrar

22 S. Greene St. Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

. Woodrow

MAY 21 2010

9

31. Date filed (Month, Day, Year)

James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year **JESSYE** 05720/2010 CURTIS L. 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BON SECOUR HOSPITAL 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Days SC 0471571920 Director Yrs. 218-12-0171 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director BALTIMORE MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral USA 21217 1139 N. FULTON AVENUE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2 No Specify: 'natural", BLACK 3 ♥ Widowed 4 □ Divorced Specify: Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY COUNSELOR of Health and Mental Hygie If item 27 is marked other in other traumatic event, <u>tt</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta.
Important if item 27 is marked to any injury or other traumaticance. မ MARIE BELL WILLIAM DUPREE STARKS, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 N. FULTON AVENUE, BALTO., MD 21217 CASSANDRA M. CURTIS/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State ON SITE CREMATION CT. 05/21/10 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC ai 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RESPIRATORY Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit Exami The law requires that the death certificate be executed Due to (or as a consequence of). resulting in death) Last Physician/Medical the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: asn. 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the a be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 은 1 DOA this Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide injury 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier . License number world 901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 161 un)

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Box 68760

Records,

of Vital

Division

32. Registrar's Signatu

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		1623 E. Lafayette Ave	enue				imore								
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I		y) If Un Mon	ths Days	If Under Hours	24Hrs. 8 Min.		Birth (MM/DD/)	For	Foreign		
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Maryland 28a-f show any d at once.	lor	10a. State 10b. County	na		Town or Lo								1 XYes	City Limits 2 No	
the Mary sa or 28a-	Director	10e. Street and Number 1623 E. La	fayette	Avenue	•		Tip Code 21213	}			10g. Citizen o		country?		
r death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	A	arried Armed F	2 x xNo	.S. 13.		cify Cuban,	Mexican,			,	White, etc		Black,	
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MD 2. d 2 should th and M n 27 is m.	- 1	19a. Informant's Name/Relations Willie Crawl	, , ,, ,	ner	19b. Ma	ailing Addre	ss (Street: Bann	and Numb	berorRura ⊜r Wa	ay M	umber, City or linto: ichiq	Town St n To an,	tate, Zip Code) WNShip 48038	.	
Baltimore, I permit. Pages 1 and Department of Heal Important: If item		20a. Method of Disposition 1 Burial 2 Cremation		from State	Place of Dis	sposition (N or other plac	ame of ceme	etery,	D	ate	20c. Loca 0 Bal	tion - City	or Town, State	!	
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/Medical caminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Smoke Int	nalation and	_	Injuries								Onset and eath	
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ion of Vital Records, P.O. Box 68760, fending Physician: The law requires that the death certificate be executed eath. for: After this certificate has been signed by the attending physician and the fumeral director, page 2 should be detached for use as the burial - transitions.	Physician/Medica	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	he 1 Live	, outcome of preg birth mant at time of de	2	Fetal deat	_	Ectopic	pregnancy		23d. Da Mor	ate of deliv	very Day	Year	
b. Bo the dear	Phys	1 Yes 2 No 9 ✓ Un Part II. Other significant condit	Ja Culik		esulting in t	the underlyi	na cause aiv	ven in Par	rt I.	23e. Did	tobacco use	contribute	e to the cause of	f death?	
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of Vital Recing Physician: The After this certificate Uneral director, page	၉	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 e of Injury	ER/Outpa		DOA 28c. Injury				Residence e how injury o		ther: Scene		
Sion of Attending Ph death. ector: After t	Certification:	1 Natural 5 Pen	ding stigation May 9,	th, Day,Year) D: 2010	FOUND 1707 hrs): s	1 Ye	es 2 🗸	No Vid	tim of a	accidental	house f			
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: completely filled in by the fi		4 Homicide dete	ermined (Specify	Townhous	e / Rowh	nouse			162	or Town, 23 E. Lafa	, State) ayette Aveni	ue, Baltir		umber, City	
o the H ithin 24 o the Ft	Medical	(Check only Certifying P	hysician: To the be aminer: On the basis and manner	of examination a											
F × F ő	ğ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, O.C.M.E. May 10, 2010										ar)			
1 1		30. Name and address of person	,		n 23a)		U.U.IV	1.E.			iviay IC	, ZU IU		·	
10		Ling Li, MD Assista	ant Medical Exa	aminer 111	Penn S	treet, Bal	ltimore, M	/ID 2120	01						
S Regis	tate trar	31. Date filed (Month, Day, Year)	O Lesar	Registrar's Signat	par										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month acqueling Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Bifthplace (State or Foreign Funeral 1 M 2 XF Hours Min. Months Country) Director 216-62-5721 Yrs. 2-14-1953 Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Windsor Mill Baltimore MD 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21244 USA 3215 Northmont Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 Yes 2 No Specify: 3 Divorced Specify "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 'th and Mental Hygiene.'7 is marked other. Elementary/Seconday (0-12) College (1-4 or 5+) State of MD Retirement Svcs 12th Director of office service t. Page 1 and 2 should be filed with thent of Health and Mental Hygier rtant: If item 27 is marked other thury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 1 be 1 Gloria E. Stovall Edward P. Gaskins Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 Northmont Road, Windson Mill, MD 21244 Harry E. Cole/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 5-24-2010 Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. ON 9200 Liberty Road, Randallstown, MD 21133 23a. Parta. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Examiner Director Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed bunal-transi and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the 98 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ò Month Day Year detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Certificate: To Be Completed by pe stro intestinal 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of aspergillus 24a. Was an has page 2 autopsy performed' this certificate 2 🗆 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death. neral Director: After that filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 \square No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

and address; of pe

31. Date filed (Month.

d cause of death (Item 36a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marilyn Ray Clark Month Mav 16 :45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. 8917 Mavis Avenue Nottingham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Maryland Months Days Hours Min. Director 7-24-0945 4 January Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2X ☐ No Balto. Md. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8917 Mavis Avenue 21236 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify. Completed 3X☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than jury or other traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Office Clerk Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John M. Dippel Louise Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Clark DTR. 305 W. Sixth Street Bethany Beach, Del.19930 Department of Health Important: If item 2's any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5-20-2010 4 □ Donation 5 □XOther (Specify Entombment Gardens of Faith Balto. Md. 21. Signature of Fundamerice Lice 22. Name and Address of Facility Schimunek Funeral Home <u>9705 Belair Rd. Nottingam, Md.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ encer disease or condition Month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, je Due to (or as a consequence of): if any, leading to immediate Examin Cause (Disease or iinjury that initiated events burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown the be detached 9 🗌 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 18/10 iman 30. Name and address of person w SQUARE 9 o completed cause of death (Item 23a) (Type, Print) 00 MO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** If Under 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Min. Director 27 is marked other than "natural", or items 23a or 28a-f shov or traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 🗶 No Completed 3 Widowed 4 Divorced S 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working

We DO NOT use retired) conday (0-12) College (1-4 or 5+) Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, 2 Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death
Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 124 Funers after death.

Funeral Director: After this certificate Poleted filled in by the funeral director, pagr 1 Yes No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? ↑ Natural iniury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check *Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 8 being 30. Name and address of person who completed se of death (Item 23a) (Type, Print THELMA 31. Date filed (Month, Day, Year, 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1200 PM Ma 2010 10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, 7 10d. Inside City Limits show Examiner must be notified at 1 ☐ Yes 2 X No Director 28a-f 109 Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 20774 items 23a by Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) lerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tarris ဂ္ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or York Road Kaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other r permit. Pages 1
Department of H
Important; If ite
any injury or ot 1 Burial 2 Cremation Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b director, page 2 s autons 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 3 🗆 DOA 1 Inpatient 2 ER/Outpatient 4 \square Nursing Home ၉ 5 Residence 6 Other (Specify) nours after death.

neral Director; After this of filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Pending investigation (Month, Day 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide e Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 2 the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

egistrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Physician/ **CHEVANNES** GWENDOLYN I. Medical Pacility Name (if not institution, give st eet and number of Death City, Town, or Location Examiner ta 6. Sex 1 ☐ M 2**XX**F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC. 29 7. Age (In yrs. last birthday) **Funeral** ^{Yea}r) 1<u>917</u> Months Days Min. Hours Yrs Director 135-68-6576 92 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10h Counts 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MARYLAND HARFORD CO **ABERDEEN** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 909 JOYCE COURT 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 🖾 No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade DOMESTIC/HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental is marked ည pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. THOMAS FORBES unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21001 909 Joyce Court, Aberdeen, Carmen G. Chevannes/Daugh-N-Law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-19-10 BALTIMORE, MARYLAND **METRO** CREMATORY 2. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 21. Signatur of Emily 23a. Part Lente-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. con Immediate Cause (Final arcinoma Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician; The law requires to the law requires to the terdeath. Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an has autopsy performed^a After this certificate Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 16 မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled is Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/17/10

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Kamnicen 31. Date filed (Morfth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3 Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 Yes 2XXNo

PANAMA

ounty of Death

U.S.A.

SELF

14. Race - American Indian.

Specify: BLK/PANAMANIAN

Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

Harrespe Coal MD 21078

DHMH 17 Rev 7/2009

State Registrar For State Registrar

1. Decedent's Name (First, Middle, Last)

MILauris 1100 Keralitian St

32. A strar's Signature

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			For State Of State Registrar	iviaryian		tificate of		ı ivlental Hy	•		
			Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
	Physicia Medio		Helen Julia Cumiskey		· · · · · · · · · · · · · · · · · · ·			May 1	$3, \frac{9}{2}$	2010 Year	10:28 A™
	Examin	er	4a. Facility Name (if not institution, give street and numb	er)		4b. City, Town	or Location of De		4	c. County of Death	
100	Funeral	Н	Sunrise Assisted Living 5. Social Security Number 6. Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Yea	Rockvill ar I If Under 24 H		rth	Montg	omery place (State or Foreign
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	yland -f show ed at	ctor	10a. State 10b. County	10c. Cit	y, Town or Lo	cation			-		10d. Inside City Limits
	r 28a notifi	Funeral Director	Maryland Montgomery 10e. Street and Number	R	ockvil	1e 10f. Zip Code			10 0	citizen of What Cou	1 X Yes 2 No
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	tems tems	Fun	11. Marital Status 12. Was Deced		S. 13. V	Vas Decedent of		(Specify Yes or No- erto Rican, etc.)		14. Race - Ameri	can Indian,
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<u>Mai</u>	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (Type, Print)							or Town, State, Zip	,
ē,	f Heal item 2		Barbara C. Duncan/Daugh 20a. Method of Disposition	John D	Diago of Diago	nition (Name of				laryland Location - City or To	
Baltimore, Maryland	Page ment o tant; If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	tate Mon Cre	emetery, crem itgomer ematori	natory or other p y um. Inc		y 16, 10 ,	 Bet	hesda, M	aryland
Ball	permit. Page 1 and 2 should be filed Department of Health and Mental H, Important: If item 27 is marked out any injuy or other traumatic even once.		21. Signature of Funeral Service Lice see	мо15				neral Home/ Venue, Rock		ville, Inc. e, Maryland	
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χ X	h certi tendin r use a	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome the past 12 months?	me of pregna		Ectopic pregna	ncy			23d. Date of deliv	
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<u> </u>	nysicia nis cer direct	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatien		thor	, ,	dence	6 🕅 Other (Specify	Assisted Living
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours afferd death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident Investigation	injury <i>Day, Year)</i>	28b. Time of injury			28d. Describe			
VISIO	or Atter fter dea irector: n by the	Certificate:	3 Suicide 6 Could not be	Injury - At ho , etc. (Specify		et, factory, office		28f. Location (S City or Tov		nd Number or Rura e)	l Route Number,
5	ospital hours a ineral C	Medical (29a. Certifier 1 Certifying Physician: To the bes	t of my knowl	edge, death o	ccured at the tin	ne, date and place	, and due to the ca	iuse(s) a	nd manner as state	ed.
	the Ho hin 24 the Fu	Mec	(Check 2 ☐ Medical Examiner: On the basis only one) 3 ☐ Certifying Nurse Practioner: To	the best of my	n and/or investi y knowledge, d	eath occurred at	the time, date and	d at the time, date a place, and due to the	and place ne cause	e, and due to the ca (s) and manner as st	use(s) and manner stated. ated.
-	or wit		29b. Signature and title of certifier	m)		se number			ate signed (Month,	
			30. Name and address of person who completed cause	of death /Itam	23a) (Time D	D34	590		Ma	y 14, 20	10
			Roy Fried, M.D. 7758 Wis		, , ,, ,		Bethesd	a, Marvla	and	20814	
	Stat			istrar's Signat		4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year **Physician** May 10. 5:30 A M Gloria Marie Carpenter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Laure1 227 Faston S. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 63 Director 329-42-2312 Illinois April 12, 1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits with the Marylan show ? is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examinar must be notified Director 1 ☐ Yes 2 X No Laurel Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724-2107 USA 227 Easton S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married □Yes 2 X No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White ۾ Specify: 3 Widowed 4 Noivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Inc. M. Once. Elementary/Secondary (0-12) College (1-4or 5+) Daycare/Self Employed Pre-School Teacher/ Daycare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Mortiz Louis Viets ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
227 Easton S., Laurel Maryland 20724 Lester G. Ensley - Companion 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem. May 24, 2010 Laurel, Maryland 21. Signature of Funeral Prvice Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 MO1 234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACULE Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 Other (specify) ed by the a 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Mellitus icate has been sig , page 2 should b 1 TYPES 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq 1 Residence 6 \subseteq Other (Specify) 1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

K

State Registrar 31. Date filed (Month, Day, Year)

NAY 21 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luis A. Cascas, M.D. 14207 Laurel Park Drive #103, Laurel, Maryland 20707

D24997

5/10/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM onec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death when Maryland Hospital Conter 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. **Director** Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 20748 9 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items; amy injury or other traumatic event, the Medical Examiner musonge. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed 100 Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>IUN</u>Q a Be 17. Father's Name (First, Middle, Last)) 13. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6800 SUITLAND ROAD SUITLAND, MARYLAND L. SIZEMORE/DGT. TRACEY 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Priverdal 4 Donation 5 Other (Specify) verdale C Signature of Funeral Service Licenses В. JENKINS FUNERAL HOME 22. Name and Address of Facility J. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and Due to (or a attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death page 2 should be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Whitenown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? After this certificate 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one, 1 Yes Other 1 Dopatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 4 hours after death.

-uneral Director: After this ted filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Tes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours To the Funeral Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month inda Dellavalle May 2010 12:24 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 70 214.42.5801 0.14.1939 N Y Usual Residence of Decedent or 28a-f shov notified at 10a State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Prince Georges Adelphi 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 10900 Bornedale Dr. 20783 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Public High School English Teacher is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filled the to Health and Mental H trant; If item 27 is marked ot njury or other traumatic ever ည Curtis McLucas Bushnell Helen Charlotte Aberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Gill/daughter 10900 Bornedale Dr., Adelphi, MD 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1.
Department of I
Important: If it
any injury or of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crem. 05.20.10 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit CAFA/Stephen D. Lohrmann, PA 8717 Green Pastures Dr. Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or impory that initiated events resulting in death) Last Examine Due to (or as a consequence of) and -transit that the death certificate be executed Due to (or as a consequence of): the burialattending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year the be detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate Yes Division of Vital or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 2 WNo Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; A 1 Yes 2 No 2 Accident
3 Suicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number Leina Bacchus, MD May 16, 2010 NPI 1336374321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pafeera Bacchus 22 South Greene Street, Baltimore, MD 21201

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAYDay 20 2011 Alma Lillian Dausch 6:47F Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medical imone Saint Joseph 5. Social Security Number 6. Sex If Under 1 Year ___ If Under 24 Hrs. 8. Date of Birth
(Month, Day, Ye
June 14, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Hours 232-28-8609 87 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 2922 Grendon Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Franklin Square Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eddith Bragg John Coiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Dausch - Son 3425 Howell Court, Abingdon, Maryland 21009 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Most Holy Recemen Cem. May 25, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkville 21. Signature of Funeral Service Licensee 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 1 ☐ Yes ∠≠ 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC 1 Yes 2 No 3 Probably 4 Nowknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 this certificate has performed Yes 2 No 2 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 20 00015458 1/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	Certificate of Death	Reg. No.
Physician/	1. Decedent's Name (First, Middle, Last) Lawrence E. Doyle	2. Date of Dec	Day Year
Medical Examiner	4a. Facility Name (if not institution, give street and number) 6923 Cable Drive	4b. City, Town, or Location of Death Marriottesville	4c. County of Death Carrol1
Funeral Director	5. Social Security Number 212-48-3477 6. Sex 7. Age (In yrs. last bit) 63	rthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day U00/29)	
-f show ed at ctor		vn or Location	10d. Inside City Limits
leath with the Maryland items 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and Number	10f. Zip Code	1 ☐ Yes 2 🕅 No
r items 2%	6923 Cable Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21104 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Usa 14. Race - American Indian, Black, White, etc.
-0036 ours after or sal Examin eted by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 No Specify:	Specify: White
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	(Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5.)	a. Decedents obtain occupation (Give kind of work done during most of working life. DO NOT use retired) ire Supply Sales	16b. Kind of Business Industry F.L. Anderson Supply Co.
yland 2 lid be filed v Mental Hyg marked othe artic event, To Be	17. Father's Name (First, Middle, Last) Gregory E. Doyle	18. Mother's Name (First, Middle, Margaret Young	Maiden Surname)
y, Mar nd 2 shou ealth and m 27 is m		b. Mailing Address (Street and Number or Rural Route Numbe 923 Cable Drive Marriottsvill	
imore Page 1 arent of H ant: If itee	1 Rurial 2 Cramation 3 Removal from State Cemete	of Disposition (Name of ery, crematory or other place) Dunty Cremation 05/18/2010	20c. Location - City or Town, State Sykesville, Md.
Balti permit. Depart Imports any inji	21. Signature of Fuderal Septice Licenses	22. Name and Address of Facility Haight Fund P.O. Box 195 Sykesville, Mo	
Physician/ Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	not enter the mode of dying, such as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death Min 4 17
Examiner	Due (or the a consequence	of):	
Scuted and transit	Sequentially list conditions, if any less including the conditions of the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence		
8760 %. Ifficate be executed and physician and as the burial-transit Medical Examiner	d.		
Division of Vital Records, P.O. Box 68760 with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Medical Certificate: To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death g ☐ Unknown		23d. Date of delivery Month Day Year
JS, P.C uires that in signed build be dett	Part II. Other significant conditions contributing to death but not resulting		bacco use contribute to the cause of death? Yes 2 - No 3 - Probably 4 Denknown
Records, it The law require icate has been significate by page 2 should the Completed		24a. Was a autop perfo	
· Vital hysician: his certific	25. Was case referred to medical examiner? 1 Ves 2 No No No No No No No No No No	26. Place of Death (Check only one) Other: 4 Unursing Home 5 Resid	ience, 6 Other (Specify)
ivision of or Attending Prafer death. Director: After the in by the funeral Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ow injury occurred
Division atternate of in by the in by the in the in by the in the internate of in by the internate of in the internate of	3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office 28f. Location (S City or Tow Mariot 4	treet and Number or Rural Route Number, n, State 6933 Cable Valle Walle
he Hospital in 24 hours he Funeral pleted filled	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/	death occured at the time, date and place, and due to the cau or investigation, in my opinion, death occurred at the time, date a vledge, death occurred at the time, date and place, and due to the	use(s) and manner as stated.
s d with the sum of th	29b. Signature and title of certifier	1:	May (7, 20 to
13	30. Name and address of person who completed cause of death (Item 23a) Herbert P. Hembertson S. M.D. 3		Manchester MA21102
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		VIVIO III III VIVIO
DHMH 17 Rev 7/2009	penon B. Mar	C	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:46 AM DONNIH DRIVER 2010 Mar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Johns Hopkins Bayview Medical (Inter If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Hours 02/24/1964 New Jersey 158-68-9079 46 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Ex miner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 903 North Iris Avenue 21205 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes Yes No Specify. Specify: White "natural" 3 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerry Jerome Flint Bonnie Sue Algor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
903 North Iris Avenue, Baltimore, Maryland 21205 Charles Talbert Driver (Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/20/2010 Baltimore, Maryland Bayview Crematory, Inc. 4 Donation 5 Other (Specify) Fringe | Service | Tensee 22. Name and Address of Facility P.A. Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASYSTOLIC AKREST Physician/ dise e or condition re (Iting in death) 36 MINUTES Medical Due to (or as a consequence of): **Examiner** VENTRICULAR ARRIY TITHERA 5-101121 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Dire to (or as a consequence of MITTER DISEASE 10 tems attending physician and for use as the bunal-transit CORDIVARY Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 🔲 Yes 2 🔲 No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MAY 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID CITHURG, M.D. 4940 Eastern Avenue, Battimure, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 2010 6:00 P M Elizabeth Tucker Ellinghaus Lee April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4330 North Charles Street Baltimore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours 02/15/1925 Mary Land 214-26-5449 Director 85 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 4330 North Charles Street 21218 U.S.A death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married 72 hours after Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiei Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cummina Tucker Gladvs Elizabeth Emrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ellinghaus / Daughter 346 Willow Street, <u>New Haven, CT 06510</u> 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 05/10/2010 | Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Metastatic Bladder Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician at the burial-Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes s been signature should be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s the Hospital or Attending Physician: The law autopsy certificate Yes 2 K No 1 Yes 2 No 25. Was case referred to medica director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\frac{\mathbf{X}}{2}\$ Residence 6 \subseteq Other (Specify) 1 Tes ည 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Suicide Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shrough D66049

State Registrar 31. Date filed (Month, Day, Year) =

DHMH 17 Rev 7/2009

Richard Schraeder M.D., 7501 Osler Drive, Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May PBY 2010 1:48 AM Edna Elizabeth Eber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🛛 F Months August 14, 214-24-2267 1928 Marvland 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 🌡 No Maryland Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Rain Flower Path, #203 21152 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Henry Bohnlofink Caroline Wilhelmina Roeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Eber/son 12365 Greenspring Ave. Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulaney Valley Mem GardMay 24, 2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney Vall 200 E. Padonia Rd. Timonium, MD 21093 P. 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined e Funeral (Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 30. Name and address of person who completed se of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

6701

10-03762 Gary Fuller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicial ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Gary L. Ful		2. Date of Death	Day Year	3. Time of Death 1204 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Way 10, 20	4c. County of Death	120 7 7.10
Francis		St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24Hrs.	8 Date of Righ	(MM/DD/YYYY) 9. Birth	uniaco (Stato os
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D 21 should and Mei 7 is man	٢		b. Mailing Address (Street and Number or Ru			
e, MD 1 and 2 sho Health and Fitem 27 is		20a. Method of Disposition 20b. Place	10 S. Kresson Stre of Disposition (Name of cemetery, tory or other place)		20c. Location - City or T	
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Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mar 1101 E. North Av			21202
Physician /Medical		23a. Part Firter the disease, or complications that caused the death. Doin failure. List only one cause on each line.				Approximate Interval Between Onset and
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ox 6876 eath certificat attending ph	ian/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnan	су	23d. Date of delivery Month Da	y Year
Box 687 c death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
P.O.	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a Certifier 1 Check only 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or i				
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		+amily vulue, nis	O.C.M.E.		May 17, 2010	
D		30. Name and ddrews of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine	r 111 Penn Street, Baltimore, MI	D 21201		
St Regist	ate	31. Date filed (Month) Da2) Year) 2010 32 Registrar's Signature	bar.			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 039am James Forbes Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death itimore Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F April 18 Months Min. Director 214-48-5743 64 Maryland 1946 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 S. Charles Street 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 K Married Specify: black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced is marked other than "natur raumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) load driver construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Forbes Mary Otis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolanda Forbes/daughter 3966 Suitland Rd #3; Suitland, Maryland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) in state ^{22.} Name and Address of Facility Board; 655 W. Baltimore Street Maryland 21201 Baltimore, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) to (or all a consequence of) Examiner eumonia Sequentially list conditions, thany leading to transcript cause. Enter Underlying Cause (Disease or iinjury that initiated events One to for as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified 25. Was case referred to medical examiner? 1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) r of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work' 2 Accident M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one) 29b. Signature and title

KYLE MARSHALL, MD

15/10

Baltimore, Maryland 21215-0036

		State Registrar			Cer	rtificate of I	Death		eg. No.	0 159		
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amine	er	4a. Facility Name (If not institution, give	ŕ				r Location of Death		4c. County of Dea			
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ctor		156-22-1214 Usual Residence of Decedent	⊠ M 2□ F	77	Yrs.	Months Days	Hours Min.	(Month, Day, 07/20/1	Vear) C L932 Ma	ryland		
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pletely fil	Medical Certi	(Check only 2 Medical Exa	and manner sta	ated.	5, m	ρ 29c. Licens	se number 7 4 5 1		19d. Date signed (Mor			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13.2010 Becky Jane Gerlowski 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Howard 4b. City, Town, or Location of Death 6124 Lori Lane Elkridge Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 👿 F Director 214-68-0074 39 JuMVth307, Y1970 Mary Land Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗋 Yes 2 🌠 No Howard Elkridge Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6124 Lori Lane 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Xio 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. <u>ک</u> 1 Never Married 2 X Married Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩XNo Specify: Completed 3 Divorced Specify: White Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) High School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ernest Bellin Lois Simmerling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Gerlowski/ Husband 6124 Lori Lane, Elkridge, Maryland, 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory 5/17/2010 Glen Burnie,Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHOM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Month Day Year 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAUCET 1 Yes 2 No 3 Probably Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director; After this certificate I performed 2 🗌 No ☐ Yes 200 No 1 Tyes completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Mariner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

11CHOLD

d address of person who completed

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 2010 Griffin Vernon Tyrone 11:10 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chatford Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthp: Country) MD 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F 218-86-3517 Hours Min. (Month, Day, Year) 6-14-1964 **Director** 45 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f MD 1 X Yes 2 No Baltimore na 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4631 Chatford Avenue 21206 USA **Examiner must** "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ ☐ Yes 2 X No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed unk unk al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Master's Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Vincent Sterling Griffin Martha Mae Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Griffin-Mother 4631 Chatford Avenue Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery5-22-2010 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISSAME disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Inijury that initiated events Examine Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death

5 Other (2001) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, Completed 1 ☐ Yes 2 W No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No Yes 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 NNo Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation after deat Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral E Medical 29a. Certifier the Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Practioner: To the best of my knowledge, seeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) DV 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1200 A M William Gurnee 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Oak Lodge Assisted Living Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 216-16-4010 86 25 July Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7753 Outing Avenue 21122 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Dept. of Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Gurnee Sarah Keyes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen M. Moran (daughter) 28162 Brouwer Way, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Мау 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2010 Baltimore, Maryland Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Inter the disease, or complic it in sthet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure to Turive 2 month disease or condition resulting in death) Due to (or as a consequence of): 513heimer's GUPATRA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Panctestiti3 Chronic 2 PNo 2 | No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medial examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It elevated Examinating must be recitived at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nr any injury or other traumatic event, If e. Mental once.

be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

The law requires that the death certificate be

/Medical

10a State

-transit physician a s the burial-1 attending pl for use as t signed by the a d be detached for peen certificate has

Physician/Medical IF FEMALE: β Completed

1∐ Yes

3 ☐ Suicide

4 ☐ Homicide

Examiner To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p မ Certification:

State Registrar

Medical

29a. Certifier 29b. Signature and title of certifie

6 ☐ Could not be

determined

nygicia

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geipe

MO 100 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d.perPHYS, G903, 5/21/2010, WS

State of Maryland / Department of Health and Mental Hygiene 5933 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GUERIN Month Physician/ RICHARD 16:304 ay g 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 X F Days Hours Min (Month, Day, Year) 6-13-1951 Country) 216-54-0367 Months Director 58 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2036 Frizzellburg Rd. ld be filed within 72 hours after death with Mental Hygiene. 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ___ 11. Marital Status 12. Was Decedent Ever in ILS. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Police Police Officer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard M. Guerin Sr. Ruth I. Mulligan other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanna M. Marley-wife
Guerin 2036 Frizzellburg Rd., Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 9 1 XBurial 2 Cremation 3 Removal from State 5/22/10 Pleasant Valley Westminster injury 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home any homas D. 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Between and Death Immediate Cause (Final Physician/ disease or condition aus Medical resulting in death) Examiner ati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 4 Pregnant at time of death
9 Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 10 Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No 1 M Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 5/19/2010 29b. Signature and title of certifier H() a C 30. Name and address of person ted caus of death (Item 23a) (Type, Print) WESTIMINSTER AUE STONER 31. Date filed (Month, Day, Year) State 32. Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April Ам RUSSELL GEORGE GRANT 20 Î 0 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, October 15 1 ፟ M 2 ☐ F 579-56-2252 66 Washington. **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 919 Sheridan Street, NW 20011-1128 or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 K Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Certified Facility Manager Year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earnest Robert Grant Louise Isabel Christine Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Pamela A. Alston - Daughter PO Box 7340, Silver Spring, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2X Cremation 3 Removal from State Beltsville, Maryland 05/17/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funer 150 vice Licensee 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ RESPIRATORY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** END STATE RENAL DISEASE Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. as been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, CRYPTOGENIC LIVER CIRRHOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The la 24 hours after death. Funeral Director: After this certificate ha ted filled in by the funeral director, page ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔂 Natural injury 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

8600 Old Georgetown Road, Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sujoy Togore, MD,

066304

2010

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maynth 17,20 Pro 11:20A M Philip D. Geissler Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Balto Social Security Number 6. Sex 14 M 2 D F **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours **Director** 220-30-0495 73 Country) 13, 1936 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Balto. Md. Timonium 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 117 Gorsuch Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, 1 Never Married 2 Married 21215-0036 þ Black, White, etc. 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Specify: traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Production Planner 16b. Kind of Business Industry Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Manufacturing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Geissler <u>Margaret Kreis</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Gorsuch Road Timonium, Md. 21093 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Ruth Geissler Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Oaklawn 5-25-2010 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 uli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death Physician/ END STAGE RENAL DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 X No death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) ျ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide after death Director: / Investigation 6 Could not be 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff To the Funeral Di completed filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b, Signature and tite 29d. Date signed (Month, Day, Year) 2010 0 erson who completed cause of death (!tem 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 32. Registrar's Signature Registrar

a.m.

2010

SSLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a, perFH, G903, 5/21/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 4 Year Gunn Beatrice VCe 5:20 AM 2010 Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death H-spit 6. S NIA Baltimore Beltimore 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day Year) 1 - M 2 X F Days Months Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No INVINI 10e. Street and Number ŏ 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 6603 Richardson 21207 LISA items Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 2 years LPN Healthcare Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Stokes dward Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trauonce. Road Guynn Cak, MD 2120 Richardson Anthony Waters Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cremation 2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address Facility Vaugan C. Greene Funeral SVCS Randallstawn MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director, page 2 should be detached for the funeral director. in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2V No Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D00 63293 of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 16, Lewis Edward Grey 2010 6:00 Р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1711 Gruenther Avenue Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours July 11, 193178 Yrs. Washington,D.C. Director 577-40-1020 Usual Residence of Decedent 28a-f shov 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1711 Gruenther Avenue 20851 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify. Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William E. Grey Mabel Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Lynda M. Papio/Daughter 18520 Kilt Terrace, Olney, Maryland 20832 20b. Place of Disposition (Name of Mont 2 Omer) Mont 2 Omer V Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State May ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 18, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20814 Pumphrey Funeral Home/ Montgomery Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Coronary Artery Disease vears Medical Due to (or as a consequence of): **Examiner** Ischemic Cardiomyopathy years Sequentially list conditions, if the sequential sequence cause. Enter Underlying Examine Due to for as a consequence of ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 1 \sum Yes Other: ည 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42110 May18, 2010

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Daniel Leonard Griffin, III, 15225 Shady Grove Road #201, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 92 GARDNER CUALD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SPRIN CROSS HOSPITA MONTGOMER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 MM 2 □ F Months Hours Min. (Month, Day, Ye Country) 70 Director 231-34-193 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MONTGOMBRY 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 20832 NK LOCHNESS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. Specify: WHLTE 3 Widowed 4 Divorced Completed UNK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) UNK NUN UNK NUN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RA 0 CROSS HOSPITAL FOREST GLEN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in State cemetery, crematory or other place) Signature of Funeral 1005 ²²State Anatomy Board; 655 W. Baltimore Street Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician, ARDIORESPIRATOR ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SPIRATION AULA Securetially list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last EREBROUASCULAR ACCIDENT Due to (or as a consequence of) The law requires that the death certificate be CARDIOVIASCULLAR IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown INDUCED HYPERGLYCEMIA STEROID 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page HYPERTENSIO 2 **N**N 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of deftifier D4786 201 05.

Registrar

State

ONEY

31. Date filed (Month, Day, Year)

RANDOI

RD

ROCKUII

4701

20852

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar'

ZUNIGAIMD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/17/2010 Rita Celine Hoburg Physician/ 3:40am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Care Center Crofton Anne Arundel 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Social Security Number 195–18–8727 1 - M 2XXF Months Days Hours 677*77*1921 Director PA Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arunde Davidsonville 1 Yes XX No 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2518 Hobbits Lane 21035 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. "natural", or à 1 Never Married 2 K Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white Specify. Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic event the Manana injury or other traumatic event the Manana Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ O'Rourke James Catherine Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Paul D. Hoburg / Son 2518 Hobbits Lane, Davidsonville MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery May 21, 2010 Pittsburgh, PA 4 Donation 5 Other (Specify) Charles L. Stevens Funeral Home, 1501 Fast Fort Avenue, Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final monar nset and Death Physician/ disease or condition resulting in death) Medical Examiner Secreptially list conditions if any, leading to immediate cause. Enter Underlying Examir ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ō 1 Yes 2 2 9 Unknown Pregnant at time of death Month Day Year should be detached the Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 1 Natural 28b. Time of s after death. 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретен The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 0 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Ø Name and address of person who completed cause of death tem 23a) (Type, Print) rez

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Chiyoko Doris Hoshide 2 0/ 0 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Jan 2 Day, 1 91 1 1 🗆 M 2 🖾 F Days Hours 99 California 538-01-5119 Yrs **Director** Usual Residence of Decedent 10a. State 28a-f shor 10b, County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Rockville 1 ☐ Yes 2 🎦 No Maryland Montgomery þ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20854 1993 Milboro Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural" Specify Completed 3 Midowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) I Hygiene. Federal Government Cartographer injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental i Important: If item 27 is marked or any injury or other traumatic eve ance. မ Shinkichi Aiso Kaku Sato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Izumi/Representative 20008 5160 Linnean Terrace, NW, Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bethesda-Chevy 21. Signature of Funeral Service Licensee Kóbert A. Fumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home/ M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Spiratory Medical Due to (or as a consequence if) **Examiner** neumunia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit rinary Iract that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been signed as 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? s certificate ha lirector, page 2 2 💢 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No ည 1 Tes 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pendina work? 2 Accident
3 Suicide
4 Homicide neral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral L completed filled

Nyoko

State Registrar

(Check only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

30

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of H rtificate of I			giene ()	10	15941
	Physicia	an	Decedent's Name (First, Middle, La Gloria	Dean	I	Huber		2. Date of Dea Month May 15	Day	Year	3. Time of Death 3:00 A M
	/Medic Examin		4a. Facility Name (If not institution, gir				Location of Death	May 13	4c. County	of Death	J.00 A
			Future Care Homew				timore	,			
	Funeral Director		218-44-7910	Sex 7. Age (In your 1 1 M 2	rs. last birthday) 3 Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat January	y, Year)	9. Birthp Coun Nort	place (State or Foreign http:// h Carolina
land	MO 18		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ecation				1	0d. Inside City Limits
Many	Hed.	tor	Maryland N/A		Baltin	more					1 X Yes 2 ☐ No
ith the	or 28	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of V		itry?
eath w	8 23s	Funeral Director	623 South Curley	Street 12. Was Decedent Ever in	115 12 1	212		acity Vac or No	US 14 Bac	A Americ	can Indian
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important; or Itema 23a or 28a-f show Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f show eny injury or other traumatic event, the Madical Exprilment mant by notified at once.	by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Ovorced	Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Specify	ck, White,	
2-6 72 hou	natura Ilcal E		15. Decedent's E	ducation ade completed)	16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. Kind of Bu	usiness/inc	dustry
iệ k	then "	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retired	1)		D		
iged ∧	Hygie other ent, II		8 years 17. Father's Name (First, Middle, Las	t)	F	actory Wo	18. Mother's Name	e (First, Middle,	Paper M Maiden Suman		acturer
	rked c	To Be	Vernon Goodman				Virgini	ia Camph	æll		
and S	and h		19a. Informant's Name/Relationship			ng Address (Street			-		
1, and 1	Health em 27 ther tr		Tammy Franklin 20a. Method of Disposition	Daughter	b 23 i	South Cur		et, Balt Date	20c. Location -		
Pages	tment of tant: If Ite		1 Rurial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, crer cred Hear	matory or other place tof Jesus	(dem. May 18	3,2010	Dundalk	, Mar	
	Depar Impor eny Ir		21. Signature of Funeral Service Lice	Connel	<i>yy</i> 7	Name and Addresonnelly F 110 Solle	rs Point	Road. I	oundalk.	P.A.	21222
	-		23a. Part1. Enter the disease, or con shock, or heart failure. List on	npfications that caused the d	eath. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory as	rest,		Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a Chr	MIC ON	strut	Melun	y 1/2/	ey		
	xaminer			Due to (or as a cons	sequence of):		,	/			
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	sequence of):						
J, executed	end -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	converse of						
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death certi	e atte	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify) _	1			ite of delive onth	ery Day Year
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ecords, F.O.	been signed should be d	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause giv	en in Part I.				he cause of death?
The law	ete has b page 2 s	Completed						24a. Was autop perfo	med?	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
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	th. Afte	tlon	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year	r) Injury	Wor	k? Yes 2 □No	200. 0030100	non injury coods	100	
DIVISION i er Attendine	after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		at home, farm, str ecify)	reet, factory, office		28f. Location (City or To		per or Rura	al Route Number,
Hospita	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, deat	th occurred at the tire	ne, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and made,	anner as s and due t	itated. o the cause(s)
Toth	within To th comp	Me	29b. Signature and title of certifier	// //		29c. Licens			29d. Date signe		
•			1		00	HOE	162638		5/18	8/10)
			30. Name and address of person wh	/ / /	Item 23a) (Type,	Print)	10%	(1/2 1	1101	11 -	M, MOZIJO
T.	Sta	ite	31. Date filed Month, Day, Year)	hun K-ch 32. Registrar's Si	P.U.	77. Pa	1/1/14L,	Just	107,134	ITM	41 L(N) 2170
	Registi		MAY 21	2010 Lenaus	A. x	barre					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh g903 5-27-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mac Day Year Johnson **Physician** May 1606 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-31-1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 J 81 Director 214-26-1775 S.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 X Yes 2 □ No Director MD na Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country Pages 1 and 2 should be filed within 72 hours after death with Funeral 21213 USA 1826 E. North Avenue Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or iten edical Examiner r 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à Specify. Specify: Black 3 ▼ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than event, the Mer tary/Secondary (0-12) College (1-4 or 5+) 12th grade na Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Uylesses Miller Lettie Nelson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a John Bullock-Grandson Department of Health Important; if item 27 any injury or other tr once, 1826 E. North Avenue Balto, MD 21213
20c. Location - City or Town, State
Baltimore 20a. Method of Disposition Place of Disposition (Name of cell of the Place of Disposition (Name of Cell of the Place of Cell of the Place of Cell of the Place of Disposition (Name of Cell of the Place of Disposition (Name of Cell of the Place of Disposition (Name of Cell of the Place of Disposition (Name of Cell of the Place of Disposition (Name of Cell of the Place of Cell of Cell of the Place of Cell of **2**7 ★ Burial 2 Cremation 3 Removal from State 5 -2010 Owings 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Nyocardia disease or condition resulting in death) Intarc /Medical Die to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine y as a pure cuertos of The law requires that the death certificate be executed burial-transit pidemia houe to (of as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has perform 1 🗌 Yes 1 T Yes 2 🗌 No or Attending Physician: after death. the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 🗍 Nursing Home 1 Inpatient 2 \square ER/Outpatient 3 🗌 DOA မ 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c Injury at Work? 28d. Describe how injury occurred s after death. Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar DHMH 17 Rev 1/2001

Medical

(check only one)

29b. Signature and title of certifier

Shanahan Rygn 31. Date filed (Month, Day, Year)

Thank

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

2010

11

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. O State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death		Reg.	No.	
Physician/ Medical Examine	1	1. Decedent's Name (First, Middle,Last) Teresa Jo Jablonski		Date of Death Month D Vlay 12, 201	ay Year 0	3. Time of Death 1946 hrs
		4a. Facility Name (if not institution, give street and number) 116 S. Main Street, Apartment B 4b. City, Town, or Location Bel Air	of Death		4c. County of Dea Harford	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea		3. Date of Birth(1	MM/DD/YYYY) 9. B Fore	
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<u> </u>	5 /	Maryland Harford Bel 106. Street and Number 106. Zip Code	Air_	I 10a	Citizen of What Co	1 Yes 2 X No
th the Maryland 13a or 28a-f sh 20tified at once		116 South Main Street, Apt. B 2101			u.:	S.A.
hours after death with the Maryland natural", or items 23a or 28a-f show Examiner must be notified at once.		11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical	n, Puerto Ric		White, etc.	rican Indian, Black,
hours afte natural", saminer	\$	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give during most of working life, DO NOT	kind of work		Specify: 5b. Kind of Business	White
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed		Elementary/Secondary (0-12) College (1-4 or 5+) 2 Cashier	,		McDonald	Restaurant
MD 21215-0036 2 should be filed within 7 and Mental Hygiene. 27 is marked other than smatic event, the Medical	3	William Allen	S		3urkhalte	
	Ĺ	19a. Informant's Name/Relationship (Type, Print) Amy Higgins - Sister 19b. Mailing Address (Street and Nur 5425 Harris Farm				
Baltimore, MD permit. Pages 1 and 2 shu perment of Health and Important: If item 27 is injury or other traumer	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da	ate 2	Oc. Location - City o	r Town, State
Baltin permit. Pr Departmen Importan injury or	-	4 Donation 5 Other Specify: Ft. Lincoln Crematory 21 Signature of Funeral Struce Licensee 22. Name and Address of Facility	ty iline	s-Rinal	edi Funera	, Maryland al Home, Inc
Physician /Medial	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. Listonly one cause on each line. Tramadol intoxication associ	cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		a. Atherosclerotic cardiovascular dor condition resulting in death)	isease	2		Death
ner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
uted d ansit Examiner		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
760, Toate be executed sphysician and the burial - transit		AMENDED 23a, 27, 28a-f, permE, g903 5/24/ IF FEMALE: 23c. If yes, outcome of pregnancy	10 TT		23d. Date of delive	
certif certif nding ise as	b	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other (Specify)	ic pregnancy			y Day Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P				24a. Was an	24b. Were a	utopsy findings available
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Division o spital or Attending hours after death. neral Director: Afte filled in by the fune Certification:		Suicide Suicide Could not be determined Specify) Suicide Could not be determined Specify) Specify) Secretify Secretify Specify	28f. Ap	Location (Street or Town, State	et and Number or R 116 S. M 21 Air, M	ural Route Number, City ain St
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u fedical Certification: To Be Completed by Physic		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.				
N F S T S N	2	29b. Signature and title of certifier O.C.M.E.		7.0	9d. Date signed <i>(Mo</i>	onth, Day, Year)
	3	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201			· · · · · · · · · · · · · · · · · · ·
State Registra	-	31. Date filed (Month, Day, Yeer) 2 1 20 0 Server S. Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 23a,e,25,21/ #4a, perPHYS#10e,f, perFH, G904,6/11/2010,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 10:50a Elizabeth Johnson 80 2010 Barney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 744 McKewin Ave. 5823 Ethelber ${ t Baltimore}$ If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Yrs. 57 53 213-64-6915 SC Director 04 02 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 744 McKewin U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St Joseph Hospital 12th grade 2yrs Registered Nurse ermit. Pages 1 and 2 should be filed epartment of Health and Mental Hygic important: if item 27 is marked other my injury or other trainmant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Lee ျှ <u>Labin Barney</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5823 Ethelbert Ave, Baltimore, Md 21215 Ernest Barney-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Mt. Zion 5/18/2010 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the divease, or complications that caus shock, or heart aillure. List only one cause on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Myocardial Infarction Immediate Cause (Fin disease or condition resulting in death) **Physician** 0 6 643 6 41 61 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Records, P.O. Box 68760, Due to (or as a consequence of) signed by the attending physician the detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 Ho 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ob Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide percertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0033330 and address of person who completed cause of death (Item 23a) (Type, Print) 3337 N. Calvers 15 Boilv. Ma. 2/2/8 John STOKE 31. Date filed (Month, Day, 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ohnson

Amend # 17 & 18 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 630AM Victor Clay Jefferys Jr. 1.7 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Oct. 4, 1 928 9. Birthplace (State or Foreign Country) WVA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F 233-42-9850 81 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Western Exacultar must be redified at MD Baltimore Middle River Director 1 ☐ Yes ≱ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Cedar Drive 21220 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Security Guard Pinkerton 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental I Victor Clay Jefferys, Sr. Tracie Bradford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3
Department of Health au Important: If Item 27 is any injury or other trauonce. Victoria Brown 33 Cedar Drive Baltimore MD 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a, Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/26/10 Owings Mills MD 21. Signatur of Funeral service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a. Metastatic adenocarcinoma of unknown Primary /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b rector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy or Attending Physician: The 1 ☐ Yes 2 1NO director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063176 5-17-2010 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRChichi Nwachinemere 9000 FRANKLIN Square DR Baltomd 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For	State of Ma	arylan	•				and M	lental Hy	giene		1.0	1 2000	010
			State Registrar			Cer	tificat	e of D	eath_			Reg. No	12.0	U	15	946
	Physicia	n/	1. Decedent's Name (First, Middle, Laura Jacobson	ist)							2. Date of Dea		010	Year	3, Time 6	
	Medic Examin		4a. Facility Name (if not institution, give	re street and number)			4b. City.	Town, or	Location of	of Death	nay 1		. County o	f Death	0.00	71
_)	Examin	eı	6304 Bannockbur					hesd					lontge		у	
	Funeral		Social Security Number 6.	Sex 7. Age		st birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h V YearL	Ĭ	9. Birthp	lace (State	or Foreign
	Director		136-03-0348	1 □ M 2 🔀 F	89	Yrs.	WIOTILIO	Buyo	, iouio		Jan. 30	, 19	21	New	York	
	nd how at)r	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation		_					1	0d. Inside (City Limits
	faryla Ba-f s tified	ect.	Maryland Montgo	merv	Beth	esda							1 ☐ Yes 2 🛣 No			
	the A or 2	Ι	10e. Street and Number				10f. Zij	Code				10g. Ci	tizen of W	hat Cour	itry?	
	n with	Funeral Director	6304 Bannockburn	ı Drive				208	17			Uni	ted	Stat	es	
	death ritem inern	/ Fui	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 1	ver in U.S	5. 13. V	Vas Deced Yes, spe	lent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe ı, Puerto I	cify Yes or No- Rican, etc.)		14. Race Black	- Americ		
<u>ي</u>	al", o	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 LJ Yes 2 🔼 I If Yes, Give Year or Dates.	No	1	☐ Yes	2 ሺ No	Specify:				Specify:	W	nite	
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2	in 72 e. han "l	ошо	(Specify only highest of Elementary/Seconday (0-12)	College (1-4 or 5- 5+	+)	life. DO	O NOT use	retired)	luring most	t ot workii	ng			-	•	
7	d with lygien ther ti	Be C				So	cial	Work					ial	serv	ices	
yland	ntal H ed ol	To B	17. Father's Name (First, Middle, Last, Benjamin Biers								e (First, Middle, letsky	Maiden	Surname)			
<u>ج</u>	ould to		19a. Informant's Name/Relationship			19h Mailin	a Addres	(Street a			l Route Number	r. City o	r Town. Sta	ate. Zip (Code)	
Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If of Health and Mental Hygiene. If field 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.		Raymond Jacobso				•				e, Beth					0817
e,	of He fitem		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	Removal from State	20b. P	lace of Dispo	sition (Nar	ne of ther place	e)	Morr	Date	20c. L	ocation - 0	City or To	wn, State	
Ĕ	Page ment ant; I		4 Donation 5 Other (Spec			gomery			n i	May 2010	50,	Bet	hesd	a, M	ary1a	nd
baltimor	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Funeral Service Lice	insheer	MO1	173 22 R	Name ar obert 557 W:	A Addres A. Pi Lscons	s of Facilit Imphre sin Avi	y Fun	eral Home Bethesda	e, Be	ethesda rylan	a-Che 1 208	vy Cha 314	se, Inc
T			23a. Part 1. Enter the disease, or con shock, or heart failure. List only											T T	Approxima	ate
	าเงราต่อเลาน	68 5	Immediate Cause (Final disease or condition			rrhyth	mia								2 nou	Death r S
	Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):										
	LAMIIIICI	ē	Sequentially list conditions,	b. Due to (or as a		Heart	Disea	ase						\rightarrow	4 yea	rs
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0 0	tificat ng phy as th	Med	IF FEMALE:			***						Т				
BOX 08/	th cer tendii or use	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of	2 🗌 Feta	Ideath 3 🗌			у				23d. Date Mon		ery Day	Year
2	e dea the a hed fo	ysic	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of d	eath 5∟	Other (s	ресіту)					1011		Duy	100
<u>.</u> ن	hat th ed by detac	y Ph	Part II. Other significant conditions	contributing to death be	ut not resi	ulting in the u	nderlying	cause giv	en in Part	1.	23e. Did to	bacco	use contrib	oute to th	ne cause of	death?
ś.	uires t n sign IId be	ed by									1 🗆 1	Yes 2	X No 3	3 🗆 Prol	oably 4	Unknown
JIVISION OF VITAL RECORDS,	v requ	Completed									24a. Was a		24b. W	ere auto	osy findings mpletion of	available
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=	Physic this co al dire	၉	examiner? 1 X Yes 2 No			ER/Outpatien			4 ∐ Nt		me 5 🕅 Resid)	
0	ding F h. After funera	ate	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injur (Month, Day)		28b. Time of injury	м	8c. Injury! work!		- 1	28d. Describe h	ow injur	y occurred	1		
<u>S</u>	Atten	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ry - At ho	me, farm, stre			103 2	_	28f. Location (S	Street an	d Number	or Rural	Route Nun	nber,
₹	alor, s afte il Dire		4 - Hornicide determined	building, etc	. (Specify))					City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Ph (Check 2 Medical Exar	ysician: To the best of a	my knowle	edge, death o	occured at	the time,	date and	place, and	d due to the car	use(s) a	nd manner	as state	d. use(s) and m	nanner stated
	the F thin 2, the F mplet	Me	only one) 3 Certifying Nu	irse Practioner: To the			leath occu	rred at the	e time, date		e, and due to the	e cause(s) and man	ner as st	ated.	
	5 ≥ 6 ⊗		29b. Signature and title of certifler	11/17	1	ml) 290	License D001	1921				ite signed 1ay 1			
			30, Name and address of person who	completed cause of de	eath (Item	23a) (Type. P	rint)									
			John Galatto, M					, #14	A, Be	thes	da, Mar	y1aı	nd 2	0814		
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure	,									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ illiam 7:28 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE UNIVERSITY OF MARY LAND MOSICAL CENTER 5. Social Security Number 216-42-5459 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Days Min. Nov. 20,1942 1 X M 2 □ F 67 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Caroline 1 ☐ Yes 2X No Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 805 Market Street Funeral 21629 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates I Mental Hygiene. narked other than "natura natic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Government pernit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Federal USDA Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Kaline, Sr. Margaret A. Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Market Street, Denton, Maryland 21629 Mrs. Diane A. Kaline / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) May 19,2010 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation letum! MO1580 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to r as a consequence of): Examiner stage Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events pue to for as a consequence of: -transit or Attending Physician: The law requires that the death certificate be executed Dia beter and Due to (or as a consequence of): resulting in death) Last the burialattending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 Pregnant g Unknown Pregnant at time of death as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown ours after death. Ieral Director: After this certificate has been filled in by the funeral director, page 2 shoul 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier P24416 15 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar STREET, BAITIMORE,

S. GREENE

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NAYAR

31. Date filed (Morth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Raymonda Marie 17 01:36 Karpe May 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne <u>Arundel</u> Peartree
5. Social Security Number House 8. Date of Birth (Month, Day, Aug 15, 9. Birthplace (State or Foreign Country) France If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** Days Hours Year) 1918 1 □ M 2 🛛 F 91 yrs. Aug 228-68-1942 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examiner must be mortified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 USA 8004 Shadow Oak Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 🖾 No White Specify Specify. þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk 12 Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be De Quenech Yves Rosalie Le Cozler ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Groseclose - daughter PO Box 1565, Millersville, MD 21107 altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brith Achim Cemetery May 20, 2010 4 ☐ Donation 5 ☐ Other (Specify) Petersburg, VA 22. Name and Address of Facility 21. Signature of Funeral Service kilo Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one caus, on each line. Immediate Cause (Final **Physician** Gent C Pau disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. detached signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Special Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day

30. Name and address of person who completed cause of death

1

completely

within 2.

(Item 23a) (Type, Print)

and manner stated.

32. Regist

1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 8:10 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death oseda . Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Months Hours Min (Month, Day, Year) 217-16-761 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Rosedale 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4 Weyhill Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: white 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working f Health and Mental Hygiene. Item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) Western Electric Machinist 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Charles J. Knott Cora S. Pfister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stoker Court-Stewartstown, Pennsylvania 110 Lawrence Knott-brother other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State Cemetery, crematory or other place)
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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Completed been s Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No Yes 2 1 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Tyes 2 X No ျှ 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA In 24 hours after deau... he Funeral Director: After th unleted filled in by the funeral funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending 1 Yes 2 🗆 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 [3 [the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G904, 674/2010, WS 17

State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THUK Monts 7:35PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 7. Age (In yrs. last birthday) 94 If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 0 M 2 □ F Months Days Hours Min. 7/40/1915 NJ **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director ral", or items 23a or 28a-f s Examiner must be notified FLLee Fort Myers YN Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4518 Windjammer 33919 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates white Specify: 3 ₩Vidowed 4 □ Divorced "natural" 2 Shbun. = ... th and Mental Hygiene. 27 is marked other than "natural"*∴ event, the Medical E? 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Packaging Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Koniq Gertrude Schmoekel other traumatic Dawn M. Konig Hillreth/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1965 Kings Landing Road, Huntingtown 20639 27 Department of Healt Important: If item 2 any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State St Jerome Cath Cemetery 5/13/10 WI 4 Donation 5 Other (Specify) Oconomowoc, . Signature of Funeral Service Licensee 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 Victor Doda 23a. Part 1. Enter the disease, o Part 1. Enter the disease, or concretations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Retween ARDIAE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law lequires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical P.O. Box 68760 as the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day I een signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 KN 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **1**00 Other: ၉ 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sighed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Pri 16GER 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ M Michael Lile Kelly May 16 4:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Montgomery Bethesda 8. Date of Birth (Month, Day, Year October 4, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Country) Louisiana 55 Yrs. **Director** 218-66-7425 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5004 Benton Avenue 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: if Yes, Give Year or Dates Specify. 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Guitarist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Ernest Kelly Helen Getchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11120 Arroyo Drive Rockville, Maryland 20852 Douglas K. Kelly/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Monters cometary or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Crematorium 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) equence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy performed 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 100 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number wind DO05 7124 117/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Truong Bao, M.D.
31. Date filed (Month, Day, Year)

32. Registrar's Signatu

10110 Molecular Drive #206, Rockville, Maryland 20850

10-03711

eisa M. Lindsay		State of Maryland / Department of Health and Mental Hy		2010	1595
•		For State Certificate of Death	Reg.		1 1333
Physiciai Iedical Examin	1/	Decedent's Name (First, Middle,Last)	2. Date of Death Month D	ay Year	3. Time of Death 1342 hrs
redical Examin		Leisa Michelle Lindsay la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 14, 201	4c. County of Death	10.12.110
		4710 Cherry Hill Road College Park		Prince George	's
Funeral	;	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birt Foreig	
Director		076-64-8573 1 M 2 TF 46 Yrs. Months Days Hours Min.	04/16/196		intry) NY
yna		Usual Residence of Decedent 10c. City, Town or Location			10d. Inside City Limits
. §	- 1				1 Yes 2 No
Maryland 28a-f show 1 at once.	Director	DC Washington 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho notified at once		618 Jefferson Street NV 20011		USA	
h with		1. Marital Status		14. Race - Americ White, etc.	can Indian, Black,
er deat	틸	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No No specify:		Specify: Afric	an-American
urs aft tural"	좕	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		6b. Kind of Business/I	
5 72 ho in "na cal Ex	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired to the control of working life.	Valid		
within gree.	dwo	12th Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Mai		orial School
21215-0036 build be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Š B		ne Crumo	den damane)	
212 ould bould by Ment s mark ic ever		Fdse Lindsav 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		r, City or Town, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	L	Fdsel M. Lindsay II / Brother 14 Sutton St. Hampstead, N	W 11550	O- I Oit	Trum Ctata
or Hear tra	- 1	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hec Important: Urier injury or other tr		4 Donation 5 Other/Specify: Metro Crematory 5/	/21/2010	Baltimore, N	
Bal permii Depar Impo		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wyl 9200 Liberty Road Randa	lie luneral allstown Ma	Home P.A. of	Balto, Co.
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. <mark>Diphenhydramine Intoxication</mark>			Death
) <u></u>		or condition resulting in death) Due to (or as a consequence of):			
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	티	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	3		
executed ian and ial - transit	۵ļ	d			
be exe	dical	UNPENDED			
Box 68760, e death certificate be the attending physicia of for use as the burie		F FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	incy	23d. Date of delivery Month	ay Year
ox 6. th cert ttendir	ig	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
that the dea eed by the a	Phy.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	he cause of death?
rds, P.O. requires that the been signed by hould be detach	2		1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
rds, require been si	Completed		24a. Was an autopsy		opsy findings available ompletion of cause of
Recol The law	립		performe		
tal Recian: The certificat	မှိ မြ	25. Was case referred to medical 26.Place of Death (Check	only one)		
of Vital ing Physician: After this certifi umeral director,	인	1 V Yes 2 No	<u> </u>	sidence 6 Other	Scene
C = : ~ 1	Ë	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 ✓ No	28d. Describe hov Subject inges		
isio Atten er deat rector by the	icati	2 Accident Investigation May 14, 2010 1310 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f, Location (Stre	eet and Number or Ru	ral Route Number, City
Divisior ospital or Attend hours after death ineral Director:	Certification:	Galcide Transfer	or Town, Stat 4710 Cherry Hill	e) , College Park, MD	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the control of the date of the d	due to the cause(s	s) and manner as state	ed.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor	
		O.C.M.E.		May 15, 2010	/ / /
	-	30. Name and address of person who completed cause of death (Item 23a)			
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CHARLOTTE MAY LEFTWICH 2010 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death rford tizen's Ursind rrace If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yea May 27, 1 Birthplace (State or Foreign Country) New York Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year 1 M 2 XF Months 92 Director 067-10-1923 191 Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Bel Air Maryland Harford 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with t 315 Hall Street 21014 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, med Force Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 ₩idowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Automotive Retailer permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Minnie (nmn) Stucke George Edward Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Watson Way, North East, MD 21901 Raymond C. Leftwich Jr./Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Re Date cemetery, crematory or other place Harford Memorial Gdn 5-21-10 Aberdeen, Maryland 21. Sign McComas Funeral Home, P.A. Maryland 21009 1317 Cokesbury Road, Abingdon, 23a Part 1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury exchrivasnur physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year is certificate has been signed by the director, page 2 should be detached 9 | Ilnknown 9 Unknown Division of Vital Records, P.O. harlotte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No autopsy within 24 hours after death. To the Funeral Director; After this certificate h completed filled in by the funeral director, page Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Be 26. Place of Death (Check only one) eftwich, C examiner? 2 1100 ျပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Suicide Investigation

State

Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 Could not be

determined

SIM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

racke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M. n

32. Rea

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AV 16 Physician/ CLEVELAND JEFFERSON LANDRUM 6:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford <u>2211 Pleasantville Road</u> Fallston 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth **Funeral №** М 2 П F 63 Months Days Hours Min Director Mar. 1947 234-76-7272 28a-f show 10a. State 10b. County with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2 InNo **Fallston** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 Pleasantville Road 21047 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Truck Driver Sod Farm is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Page 1 and 2 should be ment of Health and Ment Vinnie Ellen Cockran Leonard Moore Landrum traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 James Landrum / Brother 3001 Harford Road, Hydes, Maryland 21082 other Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 🗐 Cremation injury or val from State 5 Other (Specify) onation / <u>Memorial</u> Gdn 5-20-10 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. Abingdon, Maryland 21009 1317 Cokesbury Road, 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PERCAPNOGIE RESPIRATORY Physician/ disease or condition Medical resulting in death) Examiner Du to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv perform certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical director, **Division of Vital** Certificate: To Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director; After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check within 2 To the F Gertifying Nurse Practioner: To the best of my knowledge, death occur diet the time, date and place, and due to the 29b. Signature and title of certifier 29d. Datessigned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANUSHA-SINITHMA, 260 GATEWAY DRIVE, CUITE 21/22B

Registrar

31. Date filed (Month, Day, Year)

LEVELAND

Care

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G903,5/25/2010.WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard A. Lyons Physician/ Month 2010 11:30 AM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3568 Benzinger Road Baltimore Violetville Social Security Number 6531 If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Ye 1 🔲 M 2 🗆 F Months Days Hours Min. Year 64 Director 215-46-6536 Maryland Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No MD **Violetville** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3568 Benzinger Road 21229 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ John Lyons, Sr. Marion Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Lyons - Wife 3568 Benzinger Rd., Violetville, MD 21229 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o
once, Burial 2 Cremation 3 Removal from State May 19,2010 Atlantic Crematory 4 Departion Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, raf Service Lia ns Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) tastati Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant 9 Unknown 5 Other (specify) Day Year Pregnant at time of death the a 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 2 No 1 Yes Yes 2 5 the funeral director, 25. Was case referred to dedical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Hesidence 6 \(\sum \) Other (Specify) Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Viatural 5 Pending iniury work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 08055 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay Stephen Margolis MD 90 Painters Mill Rd. Owings Mills MD 21117 31. Date filed (Month, Day, Year)

JHMH 17 Per 7/9000

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G903, 5/24/2010, WS
State of Maryland / Department of Health and Mental Hygiene / | | | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary 3:17 PM Heather Lemaire 2010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months March 7 1 □ M 2 🗶 F Days Hours Min. 247-74-0018 89 Director Australia 1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14805 Pennfield Circle 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Newport Valler Livingstone Jeanette Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice M. Lemaire / Daughter 2024 Madrillon Springs Court, Vienna, Virginia 22182 Baltimore, July 7 pate 30 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery 2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signatore of Funeral Service bicensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 lette M01305 23a. Part 12 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricular Tachycardia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Anoxic Encephalopathy Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence of): executed Cause (Disease or linjury that initiated events detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work's 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Bichhur 11 inh D54996 May 18, 2010 30. Name and address of Person who completed cause of death (Item 23a) (Type, Print) M.D. Bichhuong N. Dinh, 18101 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 21 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 19, Physician/ 2010 10:14P Barbara Burkhardt Mullen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days .1 🗆 M 2 💢 F Hours Min. Au(40119941931 Washirhgton DC 78 Director 213-32**-**0598 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 800 Southerly Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces V Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. If Yes, Give Year or Dates. Specify: White XX Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Instructor Medical Education 5+Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Aleshire Howard Emory Burkhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Son 3811 Canterbury Road #212 Baltimore, Maryland 21218 David H Mullen 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Dulaney Valley Mem Gardens May 24,2010 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Timonium Maryland Donation 5 Other (Specify) 22. Name and Address of Faction It the ll-Wiedefeld Funeral Home Inc gnature of Funeral Se 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lancer months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 X No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 5 Pending 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, **Division of Vital** within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu To the I within 2 To the I

Baltimore, Maryland 21215-0036

State

29a. Certifier

only one)

marian

29b. Signature and title of certifier

Gr

Registrar

CRNP

82 Registrar's Signatur

N. Chal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Towson

2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R149194

29d, Date signed (Month, Day, Year)

May 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A M 2. Date of Death Physician/ Joseph Mekulski May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Baltimore 9103 Orbitan Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Aug. 14, 166-14-4717 1 X M 2 □ F Months Days Hours Min 92 1917 Connecticut Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore MD Parkville 1 Yes 2X No 10f. Zip Code 21234 10e, Street and Number 10g. Citizen of What Country? Funeral 9103 Orbitan Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) IBEW Local 24 permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Magdaleme Nedzinski Lawrence Mekulski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9103 Orbitan Road, Parkville, MD 21234 Elizabeth Infussi/Daughter Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gaffens Tallth May Rosedale, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signat Evans 8800 Service Licenses Funera Harford Chapel & Cremation Services Rd. Parkville, MD 21234 23 a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Interval Between Onset and Death Imme vate Cause (Final ONG Physician di e e or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ò in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 1 Yes 2 Unknown cate has been signed by the page 2 should be detached Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signatur address of person who co ppleted cause of death (Item 23a) (Type, Print) 30. Name and LUTHERNUE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Year 9:25A M Carl Elwood McCormick May 17 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Nursing Winfield Home Carroll Social Security Number 6. Sex (In vrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 🗆 F 84 (Month, Day, Year) 219-12-5817 Director 9-12-1925 MĎ Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at be filed within 72 hours after death with the Maryland Director 10d Inside City Limits ral", or items 23a or 28a-f sl Examiner must be notified MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 Miller Rd. 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: "natural", 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Airline Service Ramp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John E. McCormick Leona E. Pettit Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sandra L. Waxter-daughter 1510 Miller Rd., Westminster, MD 21158 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō cemetery, crematory or other place)
Garrison Forest 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Owings Mills, MD 5/25/10 4 ☐ Donation 5 ☐ Other (Specify) Signature of Eyneral Service Licens 22. Name and Address of Facility Fletcher Funeral Z homas 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (ir as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year signed by the aid be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) æ Other: 2 1 No 1 🗌 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has I

24 hours after death E Funeral Director:

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the within To the 29b. Signature and title of 29c. License number 29d. Date signed (lytonth, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) HARCCC JENO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

6 Could not be

determined

State Registrar 29a. Certifier

31. Date filed (Month, Day, Year)

10-03743 HNK UNK

Matthew Clifton Maytin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 15960

	Registrar	tificate of Death	Reg.	2 U I U	0 0 0
Physician/ ledical Examiner	Decedent's Name (First, Middle, Last)		2. Date of Death Month D May 15, 201		3. Time of Death 1655 hrs
	4a. Facility Name (if not institution, give street and number) 1207 River Road	4b. City, Town, or Location of Linthicum		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Iar 216–92–9333	ast birthday) If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth(1 Min. 3/2/19	MM/DD/YYYY) 9. Birth	ı MD
Aaryland 28a-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1 MD n/a 10c. City, 1	Town or Location Baltimore City			10d. Inside City Limits 1 XXYes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once.	10e. Street and Number 1307 Haubert Street	10f. Zip Code 21230) 10g.	. Citizen of What Count USA	ry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 3 No If Yes 3 No If Yes 6 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 7 No If Yes 8 No If Yes 8 No If Y	S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 Yes 2 No specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - America White, etc.	an Indian, Black,
5-0036 ed within 72 hours sitygiene. other than "natura the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 +	16a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us Electrical Te	ise retired)	6b. Kind of Business/Inc Construc	,
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Maurice C. Martin	Jo	Name (First, Middle, Maio DAnn S. Koto	fski	
MD 21 nd 2 should lith and Me m 27 is ma aumatic en	19a. Informant's Name/Relationship (Type, Print) JoAnn S. Martin / Mother	19b. Mailing Address (Street and Number 1501 Webster Street	et, Baltimore	re MD 21230	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical TO Be Complet	1 K Burial 2 Cremation 3 Removal from State Gleft	-	5/22/10	Baltimore	e MD
	21 Signature of Funeral Service Licensee Victor P. Do	oda 23 Name and Address of Facility Charles Steve	ens Funeral l enue, Baltim	Home, Inc ore MD 212.	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. If failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	o Force Injuries	diac or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ecuted and transit	C) c. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.):			
8 5 5	UNPENDED X AMENDED 11 per	inf g904 6-2-10 vt			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buritedical Certification: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the pregnant at time of deat yellow.	2 Fetal death 3 Ectopic p	pregnancy	23d. Date of delivery Month Da	y Year
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ital Recipion: The secretificate rector, page	25. Was case referred to medical examiner?	26 Place of Death (Cl ER/Outpatient 3 DOA Other			
of Vi ing Physi After this uneral di	1 V Yes 2 No Impatient 2 E	ER/Outpatient 3 DOA Other 1 N 28b. Time of Injury 28c. Injury at Work?	28d. Describe how		Scene
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Division o To the Hospital or Attending whithin 24 hours after death. To the Funeral Director: Afty completely filled in by the fune	Suicide Could not be determined (Specify) unknown	me, farm, street, factory, office building, etc.	or Town, State unknown, ,	·	
To the Howithin 24 P. To the Full completely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.				
F S P S E	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed (Month	ı, Day, Year)
5	30. Name and address of person who completed cause of death (Item 2 Donna M. Vincenti, MD Assistant Medical Exami	23a)		14, 15, 211	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-		

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medical Center 5 Growelt Ave, La Plata-MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hobtstorgin MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Midgle, Last, of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Randallstown Seasons Hospice 8. Date of Birth (Month, Day, Year 6. Sex . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min. 215-52-4514 1 M 2 T Months Hours 61 Yrs Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Baltimore Gwynn Oak MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 6758 Ransome Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖺 No Specify: Africian-American 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Social Security Administration Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ann Haynes Harvey Kent Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith V. McCracken/Sister 4034 Cak Road, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Garrison Forest Veterans 5-26-2010 Owings Mills, MD Wylie Funeral Home P.A. of Balto. Co. Signature of Funeral Service License 22. Name and Address of Facility 9200 Liberty Road, Randallstown. 23a. Part 1, 7 ter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ervic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit physician and Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 4 Unknown 1 Tes 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Yes 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Year) Natural 5 Pending work' Accident 1 Tes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At hor building, etc. (Specify) - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

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State Registrar

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	neral ector		218-52-3421	Sex 1 □ M 2 💢 F	e (In yrs. last 64	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 194	9. Bir Co	thplace (State or Foreign untry) VA
and	ta ta	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	ation					10d. Inside City Limits
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With th	mst be	Funeral	313 Willrich Cir	#B			210	50		10g. Cr	tizen of What Co USA	ountry?
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21215-0036 within 72 hours after greater after greater and a section when "matural" and a section an	he Medica	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4 or 5		(Give k	NOT use retired)	ation during most of work	ing		ind of Business	Industry
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Man, Man, Man, Man, Man, Man, Man, Man,	er traum		19a. Informant's Name/Relationship (Frederick A. Mar	**				and Number or Rura Cir #B 1				
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\triangle	any inj once.		21. Signatura of Funeral Service of Ice			22. In	Name and Address	ss of Facility <mark>Schi</mark> MacPhail	lmunek 1 Rd Be	Fune: LAir	ral Home , MD 210	of BelAir
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To t with	con		29b. Signature and title of certifier	~ MP			29c. License	ostai		29d. Dat	te signed (Month	Day, Year)
1	+		30. Name and address of person who	completed cause of de	eath (Item 23	la) (Type, Pr	cheso	peake D	nie, E	3el	AIR, MI	Stated. 1, Day, Year) 2010 21014.
Re	State gistra		31. Date file Machine at Y2010	32. Registra	r's Signature	tare						

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			For State Registrar		aryland / De	epartment of Certificate of	Health and M	Mental Hy	2111	0 15961
	Physic Med	ian/ dical	1. Decedent's Name (First, Middle Mary Lynne Mae	ccentelli				2. Date of De Month	Day Va	3. Time of Death
	Exam		4a. Facility Name (if not institution Stella Maris	n, give street and number)		4b. City, Town,	or Location of Death	May 19	4c. County of D	9;40P M eath alto.
	Funera Directo		5. Social Security Number 178-40-3151 Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F 6	(In yrs. last birthda 6 Yrs	Months Days		8. Date of Bir (Month, Da Septemb	th g	District and a
	Maryland 8a-f show tified at	Director	10a. State 10b. County	Balto.	10c. City, Town or					10d. Inside City Limits
	with the N s 23a or 2 ust be no	Funeral Dir	10e. Street and Number 4033 Jacinth Wa		NO	10f. Zip Code			10g. Citizen of What	1 ☐ Yes 2 🛣 No Country?
-m-	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Iteal Examiner must be notified at once.	ted by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces?		212 3. Was Decedent of If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (Speran, Mexican, Puerto F	cify Yes or No- Rican, etc.)	USA 14. Race - Ar Black, Wi Specify:	nerican Indian.
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	1 and 2 sh f Health ar item 27 is other trau		19a. Informant's Name/Relationsh Adelio Maccente 20a. Method of Disposition		se 403	3 Jacinth	and Number or Rural Way Nott	Route Number, ingham	City or Town, State, 2	Cip Code)
MAY 19, Baltimore,	mit. Page partment operant if injury or injury or ee.		1 Burial 2X Cremation 4 Donation 5 Other (S) 21. Sin ature of Funeral Service Li	pecify)	Bayview	ematory or other plac	5-24-	2010	20c. Location - City of Balto. Md	•
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MACCENTELLI rds, P.O. Box 68760	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	hysician	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	d	Fetal death 3 [ne of death 5 [☐ Other (specify)			23d. Date of de Month	iivery Day Year
MACC rds, P.	requires that been signed hould be de-		Part II. Other significant condition:	s contributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.		acco use contribute to	the cause of death?
MARY al Reco	ifficate has bor, page 2 s	Be Completed	5. Was case referred to medical					24a. Was an autopsy performe 1 Yes 2	ed? prior to c	opsy findings available completion of cause of
Division of Vital Records,	death. stor: After this cer	욘	examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	28a. Date of injury (Month, Day, Yea		t 3 DOA Other. 28c. Injury a work? M 1 Y	4 Nursing Home	5 🗆 Residen	ce 6 X Other (Speci	y HOSPICE
Divi	hours after neral Direct	ical Cer	4 ☐ Homicide determine	d 28e. Place of Injury - / building, etc. (Sp	ecity)		10	City or Town, S	*	- 1
To the Ho	within 24 h	Med	(Check 2 Medical Example only one) 3 Certifying Number of Certifying Number of Certifier	ysician: To the best of my kinner: On the basis of examinate Practioner: To the best of	nowledge, death on nation and/or investion and of my knowledge, d	ccured at the time, d gation, in my opinion, eath occurred at the t 29c. License n	ime, date and place, ar	ime, date and p	place, and due to the cause(s) and manner as s	ause(s) and manner stated. tated.
	5	30	. Name and address of person who	completed cause of death (Item 23a) (Type Pr	R149	1792	29d	Date signed (Month, $\frac{5}{20}$	
	State	. L	JACKIE JONES, CI	RNP 2300 DUL	ANEY VAL	LEY RD.	IMONIUM.	MD_2109	3	
	Registrar		MAY 21 2010	Lewis S.	gnaturgark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0800 PM ROBERT MCCALL 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAYVIEW MEDICAL CTR BALTIMORE JOHNS HOPKINS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Yorcher 13, 1**X** M 2 □ F Hours Min. Country) Maryland 214-40-9397 Director ataber Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b County 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Edgemere Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò by Funeral 21219 23a **USA** 7222 Ligman Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene, I other than " College (1-4 or 5+) Elementary/Seconday (0-12) Steel Mechanic Welder 10 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injuy or other traumatic eve once. Elsie V. Johnson Robert C. McCall Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7222 Ligman Avenue, Edgemere, Maryland 21219 JoAnn McCall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory May 19, 2010 4 Donation 5 Other (Specify) gnature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYCCARDIAL INFATZCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day 1 Yes 2 No g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗌 No Yes 2 N 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 28c. Injury at Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVE BALTIMORE, HD21224 TANYAPORN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN 201 6 /Medical 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 01/27/1962 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1'**X**M 2 □ F 217-86-5530 48 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d Inside City Limits at r 28a-f st notified a Director Md Carrol1 1 Yes 2 No Eldersburg 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò items 23a or ner must be r 6819 Fox Sedge Court 21784 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other than "" any injury or other traumout." Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No þ 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2Yrs. Dept. of Defense U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Montgomery Sr. Genevieve Cantwell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Montgomery (Wife) 6819 Fox Sedge Court Eldersburg, Md. 21784. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 05/22/2010 Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funer L Service License P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final COTONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Duir to for as a nunsequence of attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE. 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate has 1 🗌 Yes 2 🗌 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 1 - Inpatient 2 No Other: 2 ER/Outpatient 4
Nursing Home မ 3 🗆 DOA 5 Residence 6 Other (Specify) this Manner of Death 28c. Injury at Work? To the Hospital or Attending Pr within 24 hours after death. To the Funaral Director; After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Natural Accident (Month, Day Year) 5 Pending investigation Injury 1 🗌 Yes 2 \square No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my calci 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Hares

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and

a

MY

32. Registrar's Signature

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4b per doc, 10c,19b per fh g904 6-14-10 yt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	Cei	rtificate of		411G 141C/11C/1	Reg. N	0010	1596
	Physici	an	1. Decedent's Name (First, Middle, Last)					of Death h D L 3–201	ay Year	3. Time of Death
	/Medic Examin		Anthony Francis Naples 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of			c. County of Death	9:00 A M
	Examin	er	9152 Windemere Way		Sava	ge	Jessup		Howard	
	Funeral Director		070-22-0551 1⊠M 2□F	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. 8. Date Min. (Mon 11-2	of Birth th, Day, Yea 22–192	r) 9. Birth Cou 9 New	place (State or Foreign ntry) York
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation					10d. Inside City Limits
	Maryl I sho	tor	MD Howard	Savage	Jess	sup		4		1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code			10g. C	Citizen of What Cou	ntry?
	th with	ral D	9152 Windemere Way		2	0794		Un	ited Stat	es
36	be filed within 72 hours after death with the Maryland tal Hyglene. sd other than "natural", or Items 23a or 28a-f show event, the Medical Evan har must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☑ Never Married 2 ☑ Married 1 ☑ Yes, Give	No 1948-	Was Decedent of H If Yes, specify Cub 1 □Yes 2 1 No			or No- c.)	14. Race - Ameri Black, White,	etc.
9	hours tural'	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education		dent's Usual Occur	pation		16b	Kind of Business/In	
21215-0036	within 72 iene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give life. L	kind of work done DO NOT use retire	during most ed)	t of working	14.0	ept. of D	•
ğ	al Hyg other	Be C	17. Father's Name (First, Middle, Last)	1 02 1 2 3	0106100	18. Mothe	er's Name (First, M		_	or on se
<u>Iar</u>	should be filed nd Mental Hygi marked other imatic event, I	To E	Anthony Naples			Ange	elina La	Rosa		
Maryland	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	t and Numbe	er or Rural Route Jessup	Number, City	y or Town, State, Zi	o Code)
e,	1 and Healt em 27	9	Mary Ann Naples - Wife 20a. Method of Disposition				, Savage Date		1and 2079 Location - City or To	
ğ	ages ent of her; If Ite		1 Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cren Arlington					-	
Baitimore,	mit. Partme		21. Signal ref Funeral Service License							ol Home at
ñ	Der Imp any	6.7	Hark H. Sugran				-			, MD 21075
П			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	er the mode of dyi	ng, such as	cardiac or respira	tory arrest,		Approximate Interval Between
	Physician	e a	Immediate Cause (Final disease or condition a. Cardia	ac Arrhythm	ia					Onset and Death
1	/Medical Examiner			a consequence of):	T £ + -					
		er	Sequentially list conditions,	Myocardial	Intacti	on				
	cuted d ansit	Examiner	Sequentially list conditions, if they, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ary Artery	Disease					
o,	e exec ian an irial-tr	Exa	resulting in death) Last Due to (or as	a consequence of):						
68760,	rificate be executed ng physician and as the burial-transit	dica	d							
	ding page as	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy					00 I Bata at I II	
ROX	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medical		2 Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date of deliving Month	Day Year
л. О	w requires that the de been signed by the should be detached	hysi	9 Unknown							
	es tha igned be del	by P	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause giv	ven in Part I.	. 23e		o use contribute to	
ord	requir een s nould		Diabetes Mellitus					1 ☐ Yes	2	bably 4XXUnknown
Records,		Completed	Obstructive Sleep Apnea					Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u></u>	siclan: The law certificate has birector, page 2 s							performed? Yes 2	death? No 1 □Yes	2 🗆 No
=	Physiclan: r this certific ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpatier	oth Oth		of Death (Check		0 F1011 - 10	
0	ding Phys h. After this funeral di	\vdash	27. Manner of Death 28a. Date of Inju	ry 28b. Time of	f 28c. Inju	4 □ Nu iry at			6 ☐ Other (Speci jury occurred	ny)
0	Attending or death. ector: After by the fune	atio	1 ဳ Natural 5 ☐ Pending (Month, Ďaj 2 ☐ Accident investigation	y, Year) Injury		rk?]Yes 2 🗀 l	No			
Division of Vital	or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Loca City	tion (Street or Town, Sta	and Number or Rur ate)	al Route Number,
	pital ours a eral C filled		29a. Certifier 1 ☐ Certifying Physician: To the best of	of my knowledge deat	h occurred at the ti	ime date ar	nd place, and due	to the cause	a(e) and manner as	etated
	e Hospital or A 124 hours after of E Funeral Direct etely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis or and manner sta	f examination and/or in						
	To the lawithin 2. To the lawithin 2. Completed	Me	29b. Signature and title of certifier	A	29c. Licens			29d. [Date signed (Month,	
1			Padmaja S. Uday	51'	D 21	1174		5	117/2	010.
1			30. Name and address of person who completed cause of d			00 -				
7	Sta		PADMAJA S. UDAPI, 7 31. Date filed (Month, Day, Year) 32. Registra	7350 Vandus ar's Signature	en Rd, 3	80, La	aurel, Ml)		

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g903 5-21-10 yr. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Helen E. McNatt May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Middle River Baltimore 7335 Gunpowder Road 8. Date of Birth (Month, Day, Year, 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 😾 Months Hours Country) 174-30-8842 **Director** 71 Tan Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore MD Middle River 1 Yes 2 Nio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7335 Gunpowder Road 21220 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker 9th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Bryner Gladys Bassinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Trionfo /daughter 7005 Oliver Beach Road Balto. MD 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Bayview Crematory 5/11/10 Donation 5 Other (Specify, Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD ure of Fundral Service Lical see Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner VOLUME Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying 700 To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobaccourse contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No 2 🖪 Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work' 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide etermined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of signed (Month, Day, Year) 5-11-10 1337

Registrar

6/20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANGO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 18, TIEN NGOC NGUYEN 2010 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2239 Deadora Drive
5. Social Security Number 6. Sex Harford 9. Birthplace (State or Foreign Country) Vietnam 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, **Funeral** 1**X** M 2 □ F Months Days Hours Min. Director 586-12-5445 65 Apr Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits 1 Ves 2X No Harford Maryland Bel Air ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2239 Deadora Drive 21015 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race ~ American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Vietnamese 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>System Analyst</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Truong Thi Nguyen Dai Ngoc Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mylinh Do / Wife 2239 Deadora Drive, Bel Air, Maryland, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 5/24/2010 Towson, Maryland 4 Donation 5 Other (Specify) e of Funeral Service Lidensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Squamous Sinus Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No the g Unknown 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NONE. 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

68760 Box (Records, Division of Vital To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

Maryland 21215-0036

Baltimore,

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 0 MA 20/2010 D0066346. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET/KOOM 692 BALTIMOKE MD 2/23/-1007 1650 RSHANIHI MARUK OKLE ANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, Physician/ 2010 11:15 A Teresa Ella Nichols Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Maplewood Park Place Health Care Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 0ays 1 □ M 2 💢 F Months Hours October 28, 1917 Washington, D.C. 92 578-09-9231 **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🎇 No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Completed by Funeral 20817 United States 9707 Old Georgetown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Navy Hospital 12 <u>Bookkeeper</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ewe ပ Adelaide E. Vaughn James Francis Rooney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6700 Woodbine Road, Day, Maryland 21797 Bernard Schwartz/Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery May 22, 2010 Silver Spring, Maryland Rôbert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licen M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 Week Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23d Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 XNo Pregnant at time of death the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No cate has I 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🛣 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending n 24 hours after death.

Re Funeral Director; Al pleted filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

Merlyn K. 31. Date filed (Month, Day, Year)

Baltimore,

mury MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (light 23a) (Type, Print)

M.D.

Vemury,

29c. License number

D35791

980ĭ Georgia Avenue #227, Silver Spring, Maryland 20902

29d. Date signed (Month, Day, Year)

May 17, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 33PM JOE L. NEWTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Citizens Nursina Haure De Grace artor HOME If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F (Month, Day, MAY 24 MARYLAND Yrs. Director 218-34-8289 Usual Residence of Decedent fshow "natural", or items 23a or 28a-f shoredical Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MARYLAND HARFORD CO PERRYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 539 CHARLES STREET 21903 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 56/58 Specify: BLACK Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade DRIVER MRDC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ EDWARD NEWTON CATHERINE CARROLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy A. Newton/Wife Charles Street, Havre de Grace, Md., 21903 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify METRO CREMATORY 05-20-2010 BALTIMORE, MARYLAND 21. Signatur of Furer it Service Log WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILA. BLVD, ABERDEEN, MD 21001 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Ch. Vonic Immediate Cause (Final Villal Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner to (or as a consequence of) cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ó Day Month Year 5 Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Wiknown 1 Yes certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy prior to completion of death?

1 Yes 2 No 25. Was case referred to examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Division of Vital Be Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) After this 27. Manner f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury 1 atural 5 Pending 2 🗌 No Investigation Accident 24 hours after deatl 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) ပ

Registrar

DHMH 17 Rev 7/2009

State

of death (Item 23a) (Type, Print)

s Signature

who completed cause

orth, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. t's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 7:15 PM 2010 rana 6 /Medical Facility Name (If not institution, give street and number 4c. County of Death **Examiner** 9. Birthplace (State or Foreign birthday) **Funeral** Months Days Hours 9-40-1429 sual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show er traumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Funeral Director timore 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Black, White, etc. Never Married 2☐ Married 1 | Yes 2 | Your of Yes, Give Year or Dates: 1 □Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within Elementary/Secondary (0-12) College (1-4or 5+) ear Decial 15t Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar holas Mosac Department of Health Important; If Item 27 any injury or other to once. ton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 24/2010 21. Signature of Funeral Service Licensee MO155 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Immediate Cause (Final abolio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed TQsician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 5 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should b 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ■Yo 24a Was an autopsy certificate 2 □ No **Division of Vital** 1 Yes After this certification, funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To th. within 2. To the Fu (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raver Blod, Baltimore, MA 21239 5601 Loch Sangritan State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtII per me, g903,05/21/2010dhb, 25

Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. Decedent's Name (First, Middle, Lag 2. Date of Death **Physician** ullo May Grace 2010 /Medical City, Town, or Location of Death Facility Name (If not institution, give street and number) County of Death Examiner Baltimore Washington Medical Center Glan Burnie Anne Aruna If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17, 19 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🕅 F Days Director 131**-**09-8375 1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 💢 No Director Maryland Anne Arundel County Hanover 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Department of health and Mental hygiene.
Important: If item 27 is marked other than "natural" with 1 one. 21076 **USA** 7706 Harmans Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garment Industry Seamstress 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lunario Filomena Guerra G. Rosario ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. Toraldo 7706 Harmans Road, Hanover, Maryland 21076 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St Michaels Cemetery 5/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Dunmore, Pennsylvania 21. Signature of Furnital Service Wiceside

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final e house **Physician** Humerrhagio disease or condition resulting in death) /Medical Due to (or as a conseq Examiner Loagulogathy CERTIFICATION AS PROJED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š hemating, afor Intrabdomina 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been si funeral director, page 2 should i Completed due to anticoagulant therapy, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending P. 24 hours after death. se Funeral Director: After tl 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 0002248 May 18, 2010 who completed cause of death (Item 23a) (Type, Print) Burnie, MD 2106 30. Name and address of persoi

State Registrar 14 cebs

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar's Signature

Michael Pryor 10-03719 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 15, 2010 Medical Examiner 0155 hrs Michael Jamar Pryor 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 2-7-1978 32 1x XM 2 F 219-90-1126 Yrs Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits tirnore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after death with the Maryland front of Health and Montal Hygiene.
Trant: If item 27 is marked other than "natural", or items 23a or 28a-f show y or other transmatic event, the Medical Examiner must be notified at once. MD na Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1547 N. Abbotson Street 21228 IJ S Ά Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 3 Widowed specify: Black 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year ⋧ 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Temp Service 10th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delores Jeffers William Pryor, Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1547 Abbotson Street Balto, MD 21218 Delores Mobley-Mother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, timore, crematory or other place) Burial 2 X Cremation 3 Removal from State 5-21-2010 Baltimore, Donation 5 Other Specify: Greenmount 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H mette Balto, MD 21202 1101 E. North Avenue 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Stab Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. cal attending physician a UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy signed by the attending be detached for use as Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' page Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred May 15, 2010 Subject stabbed Natural 0335 hrs neral Director: Pending 1 Yes 2 V No 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2700 block of Tivoly Avenue, Baltimore, MD determined (Specify) unknown 4 V Homicide 29a. Certifier 1 To the Fun completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 15, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD **Assistant Medical Examiner** 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Yea

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18^{Day} Physician/ May Month 201⁶ Eugene Philip Parker Medical 2.50 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours Min. July 22 1924 Maryland Yrs Director 216-16-3951 85 Usual Residence of Deceder shov 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 Idlewood Road 21014 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

XXYes 2 \(\square\) No 1943 Black, White, etc. þ 1 Never Married 2 Married 1946 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩idowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Certified Public Accountant U. S. Government permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatical onge. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Parker Anna Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8232 Cypress Mill Rd. Nottingham, Maryland 21236 Karen Parker / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Bel Air ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State May 4 Donation 5 Other (Specify) 201Ó Forest Hill, Maryland 21. Signatur Funeral/Service Licensee 22. Name and Address of Eacility Evans Funeral Chapel & 3 Newport Drive Forest Cremation Service-BelAir Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or liniur) that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ≝ 9 ☐ Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🖹 No | [Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident 24 hours after death Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 4a per doc 9903 5-21-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Day Year reters Hessie Lona 1945 2010 /Medical Facility Name (If not institution, give street and number). Center CHESAPLEKE Med CHESTER 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Harford Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Director 217-40-5520 1943 Maryland Jan. 18, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at Director 1 ☐ Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2925 Grier Nursery Road 21050 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Baltimore, Maryland 21215-0036 þ Specify. 3√ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Waitress</u> Country Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 02/12/2010 Harry Elias Crissey Sr. Norma Iona Hampe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17268 William A. Crissey / Brother 10655 G&G Lane Unit 62, Waynesboro, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Natural 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 5-19-10 L Bel Air, Maryland of Fune al Service Licenses 22. Name and Address of Facility
MCCOmas Funeral Home, P.A. McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdo

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of): Webers, Bessie Moodogoof Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Disease 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy his certificate I I director, page perforr 1 Tyes 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner ? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To nours after death.

neral Director: After this y filled in by the funeral di Manner of Death 1 Matural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063981 M.D-30. Name and address of person who comple d cause of death (Item 23a) (Type, Print) 669 Revolution St., Have de Grace, Mo Benjamin Lee, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10b, per Fh G903 5/21/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** 3:50 AM 18 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 6. Sex Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2 M F Hours 213-30-302 74 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore 10e. Street and Numbe 10g. Citizen of What Country? ò 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants if item 27 is marked other than any injury or other traumes. Elementary/Secondary (0-12) College (1-4or 5+) 104h 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) oanno 19b. Mailing Address (Street and Number or Bural Route Number, Daughter 3818 Hendon Road Kundallsto Method of Disposition Place of Disposition (Name of cemetary, crematory or other place) Date Baltimore Manyland Burial 2 ☐ Cremation 3 Removal from State Woodlawn 4 □ Donation 5 □ Other (Specify) Himore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis

Due to (or as a Insequence of): **Physician** 2 Days /Medical Examiner UNKROWN Sequentially list conditions, if any, leading to immediate cause. En all configurations (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Lysis Syndrome LUMOR burial-tran and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ficate has been siç 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? 1 Yes 2 No this certificate Division of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident hin 24 hours after death the Funeral Director: the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number A + 2438946b6 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 2 5,18,10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Leili parsa, 201 & University phury, Baltimere, MD 21218 31. Date filed (Month, Day, Year) State Registrar Jenera

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			For State Registrar	State of M		ertificate of			eg. No.	10	15978
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4	Medic Examin		4a. Facility Name (if not institution, give	0 0	// ·		or Location of Death	May	4c. County	of Death/	03.03A
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	e filed within 72 hours after death with the Maryland tall Hygiene ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	1-1		10f. Zip Code		1	10g. Citizen of W	/hat Count	
Nod	ems 23	uner	11. Marita/Status	12. Was Decedent	Ever in U.S. 1:	3. Was Decedent of	1207 Hispanic Origin? (Sp	ecify Yes or No-	14 Bace	- America	n Indian
50 R 0036	after de al", or it xamine	by	1 Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give	No	If Yes, specify Cut	pan, Mexican, Puerto	Rican, etc.)		k, White, et	
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Known	shot and is m		19a. Informant's Name/Belationship (Type, Print)	19b. Ma	uiling Address (Street	t and Number or Run	al Route Number,	City or Town, Si	ate, Zip Co	O()
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altimore,	Page nent c ant: If iny or		1	Removal from State	Garry So	ematory or other pla	± 5/2	4/2010	Dwir		Mills, MD
Do B	permit. Departri Importa any inju		21. Sign Jule 1 Funeral Service Lice	Drue	y Se	22. Name and Addr	ess of Facility	eights	Flux Ave,	ora Pa H	e Home
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each line	d the death. Do not e	nter the mode of dyi	ing, such as cardiac	or respiratory arre			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as	a consequence of):	atory D	histress.	Syndr	ome.	-	Onset and Death
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0	be exe sician a burial-	-	resulting in death) Last	Due to (or as	a consequence of):						
9289	artificate ding physe as the	/Med	IF FEMALE:	23c. If yes, outcome	of prognancy			·			
Box (death ce	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3	☐ Ectopic pregnar ☐ Other (specify) _	ncy		23d. Date Mor	e of deliver oth [y Day Year
0.0	hat the ed by th detache		9 ☐ Unknown Part II. Other significant conditions		out not resulting in the	e underlying ause g	iven in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
Division of Vital Records, P.O. Box 68760	equires t	Completed by	Gastrointest	inal Ble	seding	, Chro	nic	1 □ Y€	≈ 2 1 No	3 🗌 Proba	ibly 4 🗆 Unknown
eco	ne law re e has b age 2 sh	omple	Kenal Insuf	ficiency				24a. Was ar autops perform	y p ned? d	rior to com eath?	y findings available pletion of cause of
Ital B	ician; The sertificat ector, pa	Be	25. Was case referred to medical examiner?	Hospital:		1.2	Place of Death (Chec	1 Yes 2 k only one)	No 1	☐ Yes 2	No
of Vi	Physic this cal dir	은	1 ☐ Yes 2 No	1 LY Inpati	ent 2 ER/Outpat	ient 3 DOA Oth	ner: 4 Nursing Ho	me 5 Reside	nce 6 🗆 Othe	(Specify)	
ion	De je		27. Manner of Death	28a. Date of inju			ry at	28d. Describe how	w injury occurre	d	
U)	Attending death. ctor: After y the funer		1 Natural 5 Pending 2 Accident Investigatic 3 Suicide 6 Could not	(Month, Da)	y, Year) injury	M 1 L	ryat rk?]Yes 2 ☐ No				
Divis	ital or Attending urs after death. ral Director: After lled in by the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	(Month, Da) 28e. Place of Inju	y, Year) injury ury - At home, farm, so, (Specify)	M 1 C	ryat k?]Yes 2 □ No	28f. Location (Str. City or Town,	eet and Numbe. State)	r or Rural F	
Divis	ne Hospital or Attending n 24 hours after death. ne Funeral Director: After pleted filled in by the funer	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check 2 Medical Exert	28e. Place of Injubulding, etc	ury - At home, farm, so. (Specify) my knowledge, deat	M 1 E	ry at k/r. Yes 2 No	28f. Location (Str City or Town,	eet and Number State)	r or Rural F	c(a) and manner stated
Divis			1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check 2 Medical Exert	(Month, Day on be 28e. Place of Inju- building, etc	ury - At home, farm, so. (Specify) my knowledge, deat	M 1 E	e, date and place, ar ion, death occurred a he time, date and place	28f. Location (Str City or Town, d due to the caus the time, date and e, and due to the	eet and Number State)	r or Rural F r as stated to the caus nner as stat (Month, Da	e(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per fh, g903,05/21/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A 4 AXINE 3142 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MemoRIAL HOSPITA HAVre de GRACE HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** Months Hours Min. 218-72-6810 1271571966 Director 43 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Havre De Grace 1 🗆 Yes 2 🗶 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 21078 USA 738 Otsegq Street Apt #2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Pre-School 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) Risby, Sr. ပ္ Rudolph V. Viola Akins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Harlan Avenue, Aberdeen, MD 21001 Theodore R. Akins, Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If itel any injury or oth 20c. Location - City or Town, State 1 Durial 2XI Cremation 3 Removal from State Baltimore, MD Metro Crematory Inc. 05/14/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of MD, Inc. Thomas Gregor per DVR 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Ph sician/ C disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a nonsequence of): Exami Cause (Disease or iinjury that initiated events and-trar resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. if yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ō 4 Pregnant at time of death 9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DiAbete S DEDENDENT 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deaun.

To the Funeral Director: After this of ammieted filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural work? 1 🗆 Yes 2 🗆 No 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartitying Nurse Byactionar: T. th 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar WACHSMAN

31. Date filed (Month, Day, Year)

S. UNION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 1:30 PM MAY MICHAEL OTHER ROGERS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE TOWSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** JAN. 6, 1949 1 XM 2 - F Months Days Hours Mir **Director** <u>217-52-5886</u> 61 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3661 CHESTERFILED AVE 21213 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ğ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry UNFINA (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>JAMES A. ROGERS</u> INEZ ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHESTERFIELD AVE., BALTIMORE, MD BARBARA ROGERS/SISTER 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1122 SUNRISE BEACH RD. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/13/2010 CROWNSVILLE, MD CROWNSVILLE 21. Signature of Fundral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease of shock, or heart failure. List of complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Athrosdrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Allending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed rdiomyopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown s been signal 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irrector, page 2 s 24a, Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 😿 No Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA tosnice Director: After this I in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jut, CRNP R149194 12,2010

State Registrar

DHMH 17 Rev 7/2009 MAY 2 1 201

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Chales

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

670111.

Grant

lowson.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- State Amend Item 2. Registrar	5 per me,g	anyland/ 903,05/	2992 Cert	tment of l 010dhb ificate of L	iealth a Death	and Mental H	ygien Reg. N	e _{10.} 2 N I (1	15981
	Physicia	1/	1. Decedent's Name (First, Middle, La	st)					2. Date of D	Death	,		3. Time of Death
	Medic Examine	al	Mary L. Schaefer 4a. Facility Name (if not institution, given	e street and number)			4b. City, Town, or	r Location o	April		2010 c. County of Dea	_	7:45 A ^M
-<	LXdillill		Gilchrist	· · · · · · · · · · · · · · · · · · ·			Towson		Dout	1	Baltimo		
	Funeral Director		216-20-3742	Sex 7. Age □ □ M 2 💢 F	e (In yrs. last bi 84		If Under 1 Year Months Days	If Under 2 Hours	8. Date of E Min. (Month, I Jan. 2	irth Day, Year) 2 19	9. Bi	rthplac ountry)	ce (State or Foreign)
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loca	ution					_	I. Inside City Limits
	Maryla 28a-f s otified	rect	MD Baltimon	re e	Cock	eysv:	ille						1 ☐ Yes 2 🔀 No
115	s 23a or 3	Funeral Director	10e. Street and Number 13801 York Rd., I	Jnit S306			10f. Zip Code 210	30		-	Citizen of What C	ountry	?
12 g	tter death , or item aminer m	اھ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 X		lf'	res, specify Cuba —	ın, Mexican	in? (Specify Yes or No , Puerto Rican, etc.))-	14. Race - Am Black, Whi	te, etc	
9 66	ours af atural" cal Exa	eted	3 🔀 Widowed 4 □ Divorced 15. Decedent's I	If Yes, Give Year or Dates.	10		Yes 2 X No			Т		whi	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest g.		i+)	(Give kii life. DO	nt's Usual Occup nd of work done o NOT use retired) emaker	during most	of working	16b.	Kind of Business Own Hom		try
Haryland	be filed wental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Bernard Lynch		7				r's Name (First, Middl Anne L. Ly				
ary	should and Ma is mar aumati		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street		r or Rural Route Numl		or Town, State, Z	ip Coo	de)
e, ≥	and 2: Health em 27 ther tr		Mrs. Melissa Smyr	cnioudis/da			4 Pressw			_			-
'5Aಗ್ಗಿ Baltimore,	. Page 1 tment of tant: If it jury or o		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	cemet	ery, crema	tory or other plac	.0)	20/P0e 1 Gardens	1	Location - City o		, State
175Am Baltim	permit Depari Impor any in		21. Signature of Funeral Service Income Michael	agle	>	22. L 10	Name and Address Smmon Fu W. Pado	ss of Facility neral nia R	Home of L	ulan um,	ey Vall MD 2109	ęу,	Inc.
	ç		23a. Part 1. Inter the disease, or conshock, or heart failure. List only of Immediate Cause (Final	plications that caused one cause on each line	the death. Do		the mode of dyin	g, such as o	cardiac or respiratory			A In	pproximate hterval Between hset and Death
0102	Priysician/ Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence	of):	TIPH	1000	hage			d	CLY Death
~ 1	Examiner	-e	Sequentially list conditions, if any leading to immediate	b. Due to or as a	r mountaine	off.				1	/		U
4 (cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с				0	CATION APPROVED BY	MEDICAL	EXAMINER		
(D)	icate be executed I physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a	a consequence	e of):		CERTIF	CATION APPROVED				
6876	ertificat Iding ph	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						001 5-111	1:	
Mes.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other <i>(specify)</i>	<u>-</u>			23d. Date of de Month	Da Da	ay Year
s, P.O	es that the signed by the detail	술	Part II. Other significant conditions of	contributing to death be	ut not resulting	in the un	derlying cause giv	ven in Part I.		_	use contribute t		cause of death?
acfc Records	w requir	Completed							24a. Wa	s an	24b. Were a	utopsy	findings available
Ac	r: The la icate ha r, page 2								per 1 🗌 Yes	opsy formed? 3 2 X	death?		letion of cause of
Signal Signal	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 X Yes 2 X No	Hospital:	ent 2 🗆 ER/Q	Outpatient	Othe	ar.	n (Check only one)	idonco	6 Other (See	ciful.	Horsis
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:		27. Manner of Death Natural 5 Pending Accident Investigation	28a. Date of injur (Month, Day	y 28b.	Time of injury	28c. Injun work	/ at	28d. Describe		/	cny/	100,140
Division	al or Atte s after de il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined			arm, stree	t, factory, office		28f. Location City or To		nd Number or Ri e)	ural Ro	ute Number,
(2)	e Hospita 24 hours e Funera eleted fille	Medical	(Check 2 Medical Exam	sician: To the best of piner: On the basis of exserving Practioner: To the l	camination and	or investig	ation, in my opinio	n, death occ	curred at the time, date	and plac	e, and due to the	cause	(s) and manner stated.
(10)	To th within	-	29b. Signature and title of certifier	Maaw:		-	29c. License		479		ate signed (Moni		
	'		30. Name and address of person who		eath (Item 23a)	(Type, Pri	nt) C 0 -	0	172	c- :	400	2	2 -34
	State		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	7	1. Chan	C X	J. 10W	701	CM,	2	1209
	Registra		MAY 2 1 20	10 Brown	150	gar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar ar's Signature

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy

Pregnant at time of death

Examine

(Disease or injury that initiated

events resulting in death) Last

23b. Was decedent pregnant in the

X UNPENDED

nast 12 months?

Homicide 29a. Certifier (Check only

Laron Locke MD.

31. Date filed (Month, Day, Year,

and title of certifie

IF FEMALE:

and transit signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, After this certificate has been s funeral director, page 2 should

ian/Medical

Physici

à

Completed

Be

Certification: To

Medical

State Registrar one)

29b. Signature

Director:

Fo the Funeral

completely filled in by the

1 Yes 2 No 9 Unknown	g Unknown	эресну)		
Part II. Other significant conditions	contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacco us 1 Yes 2 ✓	e contribute to the cause of death? No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical		26.Place of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2 🗸 ER/Outpatient 3	DOA Other Nursin	ng Home 5 Residenc	ce 6 Other:
27. Manner of Death	28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	occurred
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Fd 5/19/10 unk	1 Yes 2 X No	unk	
3 Suicide 6 X Could not be determined	28a Place of Injury - At home form street fact	ory, office building, etc. esidence	28f. Location (Street and or Jown, State) 24 Lutherville	Number or Rural Route Number, City 28 Chetwood Circle , MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

3 Ectopic pregnancy

M AMENDED 23a,27,28a-f,per ME g904 6/8/10 TT

5

Fetal death

Other (Specify)

Death

Year

23d. Date of delivery

Day

29d. Date signed (Mor:th, Day, Year)

May 19, 2010

DHMH 17 Rev 1/2001

OCME

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

distrar's Signature

ORIGINAL

Barkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Romaine Lawrence Schnauble Mav 19 2010 :53A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth g. Birthplace (State or Foreign Country) **Funeral** Days Hou*r*s Min Month, Day, 11/18 Director 196-18-6159 86 Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 ☐ Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 617 David Ave. 21157 USA or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10 other Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ည Guy Lawrence Claudine Groft and tis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Schnauble, Jr. - son Health tem 27 Page 1 and 2 617 David Ave., Westminster, MD 21157 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ō cemetery, crematory or other place) injury or 1 Burial 2 Cremation 3 Removal from State Westminster Cem. 5/22/10 4 ☐ Donation 5 ☐ Other (Specify) Westminster, MD Signature of Juneral Service Lice 22. Name and Address of Facility Fletcher Funeral Home Komas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ≱ Medical Examiner Due to (or as a consequence of): MICER 12,702 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ ō in the past 12 months? Pregnant at time of death ned 1 the be detact ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 2 No 1 Yes _ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: ျပ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending work 1 🗌 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifier 29d. Date signed (Month. Dav. Year) erson who completed cause of death (Item 23a) (Type, Print) ESTITUSTER, MODIST

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-16-2010 Margaret E. Stover 1015 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Spring Village Forest Hill Harford Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 93 Days Hours Min. 0801190ay 1916 213-20-7859 MD **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Forest Hill 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 1 Colgate Drive 21050 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the state of Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Clarence McKing Bertha Jones 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other **-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Rinaca (son) 1657 Jarrettsville Rd Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 05-20-2010 Timonium, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signatur of Funeral Service Licens Inc 610 W. MacPhail Rd BelAir, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RPIRATOR disease or condition resulting in death) WERN Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year been signed by the should be detached 1 ☐ Yes 2, 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and he of certifie 1002284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/esmaga 21014 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 3=40 M ma 012 Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** City, Town, or Location of Death 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 🗆 Min. (Month, Day, Country Director Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b. Count 10c. City, Town or Location Examiner must be notified at Director 10d, Inside City Limits 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 5 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Completed by 1 ☐ Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ or Town, State, Zip Code) 20b. Place of Disposition (Name of Committery, crematory or other 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State or other place nacriotsville 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Breene FuneralServi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the reference to the cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Chronic Obstructice disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury One to for as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. use as the burial-transi that initiated events Due to (or as a consequence of): has been signed by the attending physician passion 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate 1 Yes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 ther (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending s after death.

I Director: Af 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Northwest Hospital Center Randallstown Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, 235-94-6990 51 Director Dec 1058 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Brooklyn Park 1 Tyes 2 X No 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 781 Sunnyfield Lane 21225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Armed Forces? 1 ☐ Yes 2 ▼ No Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify: Specify: white 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) computer programmer printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smith injury or other traumatic Carol Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a C. Mitchell Chambliss (executor) 12347 Coleraine Ct., Reston VA 20191 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State emetery, crematory or other place)
County Cremation 5-19-10 1 Burial 2 X Cremation 3 Removal from State A11 " Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licens Parge Haught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 as nding IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy õ in the past 12 months? Pregnant at time of death 2 No ed by the a Unknown g Unknown been signed k should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Completed 1 Yes 2 No 3 Probably Anknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy death? certificate 2 🗆 No 1 🗌 Yes 1 Yes or Attending Physician: 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 7 No 유 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a Date of injufn 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 🗌 No Investigation
Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a, Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Pri 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend # 5, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0. Shaw Barbara May 2010 3:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01nev Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 22 9. Birthplace (State or Foreign Country) Maryland Funeral 1 □ M 2 🕅 F Months Days Hours Min. 579-62-9805**980**6 Yrs Director 80 1929 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Rockville 10e. Street and Number P 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 13518 Grenoble Drive 20853 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 0'Hare Edward Furr Lise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Rich /Daughter Skyview Court, Stafford, Virginia 22554 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 22, 2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Savio, Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Mugajette farme M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPS15 Medical Due to (or as a consequence of) Examiner COLON PERFORATION Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury DIVERTICULITIS that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be d IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🔲 No Accident Investigation Suicide Could not be 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records, Hospital or Attending Physician: The law requires Division of Vital within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

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State Registrar

18111 Prince Philip Drive, Suite T-12, Olney, MD 20832 Shawn Michael Tweedt, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 21 1. South

Medical

29a. Certifier

(Check

3 🗌

29b. Signature and title of certific

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

H0063193

29d. Date signed (Month. Dav. Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 10:30PM M Martha James Sayrs May 15, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Montgomery

9. Birthplace (State or Foreign Country) Rockville If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. 1 □ M 2 🗓 F Months Days Hours Director 413-94-1654 88 June 4, 1921 Chile Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Modical Exp. informatic at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Valley Road Funeral 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: ģ 3K Widowed 4 □ Divorced Mexican White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Mattie White Origen J. James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14815 Ballantyne Glen Way Charlotte, North Carolina 28277 Milton James Sayrs/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 20c. Location - City or Town, State May 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17, 2010 Bethesda, Maryland Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funer Service License M00335 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician n MUSH /Medical Due to (or as a consequence of): man Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ned by the a detached f □Yes 2 X No 9 Unknown 9 ☐ Unknowe been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 1 □ Yes 2 🗖 No 1 ☐ Yes 2 ☐ No Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after to the Funeral Direc determined 4 Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar filed (Month, Day, Year)

32. Regi

10-03718

Shawn Andrew Sullivan

Plea

ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	21	\cap	8 1	posses States	Q	Q	A
State of Maryland / Department of Health and Mental Hygiene	C. U	0	i	U	-	-	U

		1- For State Registrar		Cer	tificate c	of D	eatn				Reg. No.				
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year									П				
Medical Examin	er	Shawn Andrew Sullivan May 14, 2010 teal 2107 hrs													
*		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death							Death		4c.	County of	Death		ヿ
		Howard County General Columbia								H	oward			- 1	
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	İ	f Under 1 Year	If Under 2	24Hrs.	8. Date of E	Birth(MM/D	D/YYYY)	9. Birth	place (State or	ᅥ
Director		212-27-0001	1 X M 2 F	35	V.		Months Days	Hours	Min.	Feb.	21, 19	975	Foreign	ntry) Maryland	1
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loca	ation								10d. Inside City Limits	s
			vard		ighland								- 1	1 Yes 2 X No	- 1
faryland 28a-f show	5	3	vai u	111	rgittaliu	-,-		_							4
Mary 28a	Directo	10e. Street and Number 12745 Lime Kiln I	Pood #A			10	0f. Zip Code 207	777			10g. Citiz	Citizen of What Country? USA			
Sa or		12/4) Lulie KLIII I	NOdu #A				207	11					COA		
ms 2.	Funeral	11. Marital Status		cedent Ever in U.			ecedent of Hispa				No- 1	14. Race - White,		an Indian, Black,	П
r ite	Š۱	1 X Never Married 2 M	arried Armed Fo	2 X No	"	165,	specify Cuban, I	wiexican, Pi	ueito Ki	can, ec.)		wille,	Whi	te	-1
ifter if the line of the line	핡	3 Widowed 4 Div	vorced If Yes, Give Yea		1	Ye	s 2 X No	specify:			5	Specify:	*****		- 1
ours a	皍	15. Decedent's Education (Spe		de completed)			Usual Occupatio				16b. Ki	nd of Busi	ness/In	dustry	
n "n al Es	Completed	Elementary/Secondary (0-12)	College (1	I-4 or 5+)			of working life. [JO NOT US	e reurec	1)	1				
than thin tedic	림	12			Lat	ore	er				C	onstru	ctic	n	
ed wi	ोंड	17. Father's Name (First, Middle	, Last)				18	3.Mother's N	•			Surname)			\neg
215 oe fill rtal H ked	Be	Kevin Sullivan,	Sr.					Car	ol S	wanson					- 1
21 Mer Mer mar	힏	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailii	ng Ad	dress (Street a	and Numbe	r or Rur	al Route N	umber, City	y or Town,	State, 2	Zip Code)	ヿ
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	١.	Carol E. Hoover	- Mother		3629	Var	n Horn Way	y, Burt	consv	ille,	Maryla	nd 208	366		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "matural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition					n (Name of ceme	etery,	[Date	20c. Lo	ocation - (ity or T	own, State	╛
Ore For I		1 Burial 2 X Cremation			rematory or o		_{place)} nington Ci	rom	05/2	0/10	I a	urel,	Mary	1 and	-
Limen men rtant		4 Donation 5 Other S		1241					05/2						4
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	Mo (234				e and Address o k Funeral		Inc.		Sandy	_	_		-
	4	23a. Part I. Enter the disease, or								Laur	<u>el, Ma</u>			707	\perp
Physician /Medical	-	failure. List only one cause	on each line.				-					x, or near	`	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease				oma	atous di	isease	e of	lung	s			Death	┙
	- 1	or condition resulting in death)	Due to (or as a	consequence of):										-
	_	Sequentially list conditions,	b	consequence of	· · · · · · · · · · · · · · · · · · ·										\dashv
	<u>=</u>	if any, leading to immediate cause. Enter Underlying Cause		consequence of	1.								- 1		
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60, ate be hysic e bur	좕	IF FEMALE:	23c. If yes.	outcome of pregr	nancy	G)	903 1191	10 11	L		23d.	Date of de	elivery		╛
87 tifica ing pl	텵	23b. Was decedent pregnant in the past 12 months?				etal c	death 3	Ectopic pr	egnanc	у	,	Month	Da	y Year	
OX 68 eath certi attendin for use a	흥			ant at time of dea	ath		(Specify)								Ì
Bo deat deat	Physicia	1 Yes 2 No 9 Un	known 9 Unkno	own											╛
, P.O. Box 6 res that the death cer signed by the attendi		Part II. Other significant condit	-	death but not re	sulting in the	unde	erlying cause giv	en in Part I		1		_	_	e cause of death?	1
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ViS or A fler of Direc	읡		ld not be 28e. Plac	e of Injury - At ho	me, farm, str	eet, fa	actory, office bui	lding, etc.	28	 Location or Town, 		d Number	or Rura	Route Number, City	7
pital Di	Certification:	4 Homicide	rmined (Specify)							01 101111,	Oldio,				
Hos 24 hc Fun rtely			hysician: To the bes												
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Medical	one) 2 Medical Exa	miner: On the basis of and manner s		nd/or investig	ation,	, in my opinion, c	death occur	red at th	ne time, dat	e and plac	e, and due	to the	cause(s)	
F > F 8	ğΪ	29b. Signature and title of certific					29c. License	number			29d. D	ate signed	(Monti	h, Day, Year)	٦
		()_m).					O.C.M	.E.			May	15, 201	0		
_	}	30. Name and address of persor	who completed caus	se of death (Item	23a)										\dashv
Øl		Donna M. Vincenti, M	·	/ledical Exam		1 Pe	enn Street, E	Baltimore	e, MD	21201					
Sta	fe.	·		egistrar's ignatų		-									\dashv
Registi	ar	31. Date filed (Month, Day, Year) NAY 2 1 2010	Cersus	1 P. 19	W										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31 per DVR g903 5/21/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stump 2010 Dolores 19 6:20 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore more 6714 Gary Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 217-22-181 Months Days Hours Min. (Month 30, 1926 Director December Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6714 Gary Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Federal Government 12 vears permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Krysztofiak Sophie Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stump Husband 6714 Gary Avenue, Baltimore, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 22, 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 gnature of Funeral Service Licensee 200 ame and Address of Facility | Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. non 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final n, t and) ath Physician/ disease or condition Medical resulting in death) r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a Id be detached f g Unknown g 🗌 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, emen 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s been signated the 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5. Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1X Natural injury 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certified

Mayn 31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

License number

29d. Date

signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Schuler 2010 19 Medical 4:00 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye November 2 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Maryland Director 219-30-8769 1917 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 7 E. Lafayette Avenue 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Completed 3 Widowed 4 ☐ Divorced Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r. Elementary/Seconday (0-12) College (1-4 or 5+) 4 vears Teacher Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e James Francis Didusch other traumatic Theresa Eder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francesca Guerin Daughter 9 E. Lafayette Avenue, Baltimore, Maryland 21202 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 20, 2010 Baltimore, Maryland Bayview Crematory gnature of Funeral Service Licensee connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk.Md. 23a. Part 1. Enter the disease of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Littlenily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Pulmonun disease or condition resulting in death) **y** Medical MLEUS Due to (or as a consequence of) Examiner heat oncestive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (of as a consequence of) for use as the burial-tran that initiated events resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 9 Unknown detached 9 Unknown Division of Vital Records, P.O. à signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tricuspid Rigurgitati 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate I performed? Yes 2 X N 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) Hospital 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Grant

A. CRNP

6701 K. Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21

29c. License number

R149194

Towson, MD

May 19, 2010

	_1	State Registrar				elible ink tment of l <i>ificate of</i>			Reg. No.	UIU	15993
Physician /Medical	1	1. Decedent's Name (First, Middle, La Dolores C. SMith	st)					2. Date of D Month	Death Day	Year 2010	3. Time of Death
Examiner Funeral Director	1	la. Facility Name (If not institution, gives Saint Agreement Agree	ner Hor	Atal (In yrs. last b	irthday)	4b. City, Town, of Ba If Under 1 Year Months Days		2 8. Date of E	4c. Cou	9. Birthp	olace (State or Foreign htm) yland
nous are dean with the wayland tural, or items 23a or 28a-f show at Examinet boardified at ed by Funeral Director		Usual Residence of Decedent 10a. State 10b. County Howa	rd	10c. City, Tov	wn or Loca						0d. Inside City Limits
Director	ווברוס	MD Balti Oe. Street and Number	more	Cocl	ceysv	10f. Zip Code	Cooksvil.	l.e	10g. Citizen	of What Coun	1 ☐ Yes 2X No
by Funeral	Dy Luileia	14092 Montice11 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	o Drive 12. Was Decedent Event Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:			21723 as Decedent of Res, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		Race - Americ Black, White, e	etc.
t, the Medical E		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+		(Give kii life. DC		pation during most of wo ed)	rking		Business/Ind	·
To Be Co	ם ב	12 17. Father's Name (First, Middle, Last) Richard Pettie	4		nurs	se	18. Mother's Nai	,		thcare ^{ame)}	
		19a. Informant's Name/Relationship (Gregory Smith/s	,		1409	2 Monti	and Number or R	ive; Co	ekeysvi	lle , M	D 21723
à		20a. Method of Disposition 1	n state			ion (Name of tory or other place		Date		n - City or To	
n al	1	23a. Part 1. Inter the disease, or comshock, okheart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the	he death. Do	not enter	Baltimor	re, Maryl	and 212	01	ILTIMOT	Approximate Interval Between Onset and Death
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Physician/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal deat		ictopic pregnanc Other <i>(specify)</i> _	су			Date of delive	ery Day Year
Ş		Part II. Other significant conditions o	ontributing to death but	not resulting	in the unde	erlying cause giv	ven in Part I.				e cause of death?
Completed					·			24a. Wa aut per 1 □ Yes	formed?	death?	osy findings available npletion of cause of
Certification: To Be		25. Was case referred to medical examiner? 1		Year) 28b.	Time of Injury	28c. Injur Wor M 1 🗆	4 L Nursing F	dome 5 ☐ Res 28d. Describe 28f. Location	sidence 6 C	urred	() I Route Number,
		29a. Certifier 1 Vertifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	my knowledg	ie. death o	ccurred at the ti	ime, date and place	and due to th	e Calleg(s) and	manner as si	tated.
		one)	and manner state	ed.		29c. Licens					Day, Year)
completely filled in by the f	1	29b. Signature and title of certifier ,	MD			_	3612		_		2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, pt I&24a, per PHYS, G904, 6/1/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Triplett Month Gerard Physician/ Year 2011 370M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6/20 Baltimore Washington Medical Center tone If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

V Δ Social Security Number 6. Sex 1 **X** M 2 □ . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Aug 21, 1943 VA Director 215-42-8056 66 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 🛠 😾 No MDAnne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21122 211 Catalfa Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XXVo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: white 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Filtering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Margaret Fischer Paul Triplett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Catalfa Ave. Pasadena, MD 21122 Mrs. Deanna Joy Triplett(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/21/10 Baltimore, MD Loudon Park Cem. 22. Name and Address of Facility Singleton Funeral & Cremation Serv Signature of Funeral Service Licenses 23a. Part 1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Mesothelioma Lung Cancer SW Glen Burnie, MD Approximate Interval Between Onset and Death Physician. 10 months Medical le to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 State of Maryland / Department of Health and Mental Hygiene

			ate of Death	Re	g. No.			
Physicia Privat Exami	an/	1. Decedent's Name (First, Middle, Last) Joseph Eugene Toseph Eugene Tedor, Jr.		2. Date of Death Month May 6, 201	Day Year	3. Time of Death 1945 hrs		
K.		4a. Facility Name (if not institution, give street and number) 138 Hahn Road	4b. City, Town, or Location of Death Westminster	ath 4c. County of Death Carroll				
Funeral Director		5. Social Security Number 220-98-2008 6. Sex 7. Age (In yrs. last bin 39	8. Date of Birth 12/12/		thplace (State or Env _{ry}) and			
Aaryland 28a-f show any Lat once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Anne Arundel Hano				10d. Inside City Limits 1 Yes 2 X No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1452 Fairbanks Ave	10f. Zip Code 21076	10	g. Citizen of What Cour USA	ntry?		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of He land Mantal Hygienein (1914 in the Maryland in the Hill Hygienein on the Hill Hygienein whatural", or items 23a or 28a-fabrure traumatic event, the Medisal Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NA No	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black, White		
hours after 'natural'', Examiner	þ		1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use reti		Specify: 16b. Kind of Business/I			
, MD 21215-0036 and 24 Should be III ours, teath as About Brige me. teath as About Brige me. To a marked other than "natural raumatic event, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last)						
ID 21215-0036 should be filed within 72 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be	Joseph E. Tedore, Sr.	18.Mother's Name De1ma b. Mailing Address (Street and Number or F	Davis		Zin Code\		
e, MD 2 1 and 2 shou Health and N item 27 is n	J.	Loretta Tedore / Sister	1452 Fairbanks Ave, Ha	anover,M	aryland, 2	1076		
Baltimore, permit. Pages I an Department of Hee Important: If iter injury or other tr		1 Burial 2 Cremation 3 Removal from State cremate 4 Donation 5 Other Specify: Meadow	tory or other place) wridge Memorial 5/1	14/2010	Elkridge.N	Maryland		
Balti permit. Departr Import	ļ	21. Signature of Funeral Service Licensee	22. Name and Address of FacilityGary 7250 Washington B	Yvd:,Kau	fman Funera ridge,Mary	1 Home Inc. land,21075		
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that a dised the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (morphin)	ot enter the mode of dying, such as cardiac one) intoxication and	-		Approximate Interval Between Onset and Death		
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
'60, ate be executed physician and ne burial - transi	ledical Ex	d.	22 - 27 20 - 5	ME ~002	5 / 27 / 10 mg			
Box 68760, death certificate be he attending physical doruse as the burner of the burner and the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	23a, 27, 28a-f, per Fetal death 3 Ectopic pregna Other (Specify)		23d. Date of delivery	ay Year		
P.O. Bost that the degreed by the edetached for	by Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		eacco use contribute to t			
cords, law require has been si	Completed			24a. Was ar autopsy perform 1 Yes 2	24b. Were aut prior to coned? death?	opsy findings available ompletion of cause of		
tal Rectian: The	Be	25 Was case referred to medical examiner? Hospital: 4 Inacticat 3 FB/0	26.Place of Death (Check of Utpatient 3 DOA Other, Nursin					
of Ving Physical After this uneral dir	리	1 Yes 2 No limit I Inpatient 2 ER/Ot 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury at Work?	28d. Describe ho	lesidence 6 🗹 Other	Scene		
Division tal or Attendi s after death. al Director: A	Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be Fd 5/6/2010 Fd 28e. Place of Injury - At home, fa	7:30 pm 1 Yes 2 X No arm, street, factory, office building, etc.	28f. Location (Str	reet and Number or Rur ate) 138 Hahn	al Route Number, City		
Divisior To the Hospital or Attency within 24 hours after death To the Funeral Director:		4 Homicide determined (Specify) found at 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea		Vestmins	ter, MD			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred a		nd place, and due to the 29d. Date signed (Mon	1		
		D _ r C	O.C.M.E.	1	May 7, 2010	ur, Day, rear)		
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, M	D 21201				
St Regist	ate	31. Date filed (Month, Day Year) 1 2010 32. Registrar's Signature 6.	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19 05 2010 11:20a Helen Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Augsburg Lutheran Nursing Home 8. Date of Birth (Month, Day, 03 09 Year) 25 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√□ F MD 85 Director 213-22-9054 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 U.S.A. 2211 Westfield Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Manital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No ≥ **X**□ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elizabeth Cooney d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Certified Nursing Asst. Agency 12th_grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milbert Spicer
19a. Informant's Name/Relationship (Type. Print) Harriet Ennals 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health a permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra Westfield Ave, Baltimore, Md 21214 2211 Phyllis Way-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 ☐ Dollation 5 ☐ Other (Specify) 5/25/2010 Baltimore, Md Woodlawn 21. So natu e of Funeral Service Licens 22. Name and Address of Facility March F/H West MA 21215 4300 Wabash Ave, Baltimore, Md Patt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death THERO SCHEROTIC Immediate Cause (Final disease or condition resulting in death) EREBRO hvsician Medical Due to (or as a consequence of) Examiner Sequentiall list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-trar Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 No 3 Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□N0 or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannet of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Division 1 □ Natural 2 □ Accident 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: P death. Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 1 ASNEEM L 31. Date filed (Month, Day, Year)

AicHAM, M) 2835

32. Registrar's Signature

A. Ball

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ain

285

Smill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 599 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2010 11:03 P M Joseph T. Tesar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 85 Months Days Hours March 7, 1 🔀 M 2 🗆 F Czechoslovakia Director Yrs. 334-42-0490 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified Bethesda 1 Yes 2 No Maryland Montgomery ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6703 Greyswood Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Geza Tesar Gisela Bako 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Munch Tesar/Wife 6703 Greyswood Road, Bethesda, Maryland 20817 or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State May 20, Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 2010 Fumphrey Funeral Home/ 7557 Wisconsin Avenue 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase 1nc. Bethesda, Maryland 20814 21. Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 5 years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Myelodysplastic Syndrome disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): signed by the attending physician and defacted for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has i completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2. autopsy 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tyes 2 X No 2 1 A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural injury work?
1 Yes 2 No 5 Pending Investigation ☐ Accident ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) May 15, 2010

2 State Registrar

14/10

JOSEPH SI

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Lisa Houde McGrail, M.D.

31. Date filed (Month, Day, Year)

0065

5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Taylor 2010 17 4:30 P M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7935 St. Monica Drive Dundalk Baltimore Date of billion (Month, Day, 19 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Director 215-22-0893 Maryland January Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Baltimore Dundalk Maryland 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7935 St. Monica Drive 21222 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner .0. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify. "natural". Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Custodian Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Fitch Laura Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Taylor Husband 7935 St. Monica Drive, Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Parkwood Cemetery Baltimore, Maryland 2010 Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Termenal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Tes 2 No 3 Probably 4 nknown Hypo tayiorsism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 N 25. Was c . e referred to medical examiner?

1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) 6 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing_Home After this 5 Residence 6 Other (Specify) 27. Mayer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28b. Time of Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after a Funeral Direc determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 5118/10 Princed attanasio

State Registrar RONALD

31. Date filed (Month, Day, Year)

9114

Philadelphia Rd. Suite 108

Balt., Nd. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTANASIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year SAMUEL THOMAS 3:02P MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA BALTIMURE JOHNS HUPKINS BANJEW MEDICAL CENTER Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 265-40-932 1 M 2 □ F Months Days Hours Min. Director lordia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ħ 1 Nes 2 No Director r than "natural", or items 23a or 28a-f slifte Medical Evanirer must be rediffed 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ۵ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 D Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) actor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental is marked omas 2 19a. Informant's Name/Relationship (Type: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Ihomas-<u>wnawn</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 Deurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation _5 ☐ Other (Specify) A Funeral Service Licenses 2/10 MD2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRICULAR FIBRILLATION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YEAR MONIZOCHEMEC DILLATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. ned by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □ Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2010 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN BALTIMORE, MD LAROCHELLE M.D. 21224 AVENUE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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		į	State of Maryland / Dep	artment of Health and N	, ,	2010 16000
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg.	No.2-010 TOOO
	Physicia				Month	Day Year 5.007 M
	Medio		Arthur Lake Webster 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	<u>May</u>	11 2010 5:00A M 4c. County of Death
)		8302 Westmont Terrace	Bethesda		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Birthplace (State or Foreign
	Director		510-28-0440 1 M 2 □ F 81 Yrs.	William Days Flours Willi.	(Month, Day, Yea 09/17/19	029 <u>Country)</u> Virginia
	nd how	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	anylar sa-fs	ect	MD Montgomory Bothoods			1 ☐ Yes 2 🔯 No
	or 28	Funeral Director	MD Montgomery Bethesda 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	with s 23a ust b	era	8302 Westmont Terrace	20817	1	U.S.A.
	item:	ᇤ	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,
36	", or	þ	1 Never Married 2 Married 1 No No	1 ☐ Yes 2 ☒ No Specify:	riloan, etc.)	Black, White, etc.
Ö	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 U Widowed 4 X Divorced Year or Dates.			Specify: White
5	72 he n "na Aedio	현	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ing 16b	b. Kind of Business Industry
77	vithin jene. er tha the N	ပြီ	Elementary/Seconday (0-12) College (1-4 or 5+)	stems Analyst		Government
ק	filed v al Hyg d othe	a	17. Father's Name (First, Middle, Last)	T *	e (First, Middle, Maid	
/lar	d be i Venta arked arked	욘	Lewis S. Webster	Delta		Frazier
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	l Route Number, City	or Town, State, Zip Code)
Σ.	and 2 s Health em 27 ther tr			Vineyard Rd. NW,	Albuguerg	ue, NM 87107
ore	ela rofH lfite oroth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crei	osition (Name of gratory or other place)	Date 20c	. Location - City or Town, State
E.	permit. Page 1 Department of Important: If it any injury or o		4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gi			anover, Maryland
3a	Depar mpor my in			2. Name and Address of Facility Ana		
_						Hanover, MD 21076
			23a. Part 1. Enter the disease, or complication that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
1	Trysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Renal failure			Onset and Death
	Examiner		Due to (or as a consequence oi):	tivo nochrosathu		
		je.	Sequentially list conditions, franchistory leading to immediate	cive nephropachy		
٨	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury Stage TV adenogar	cinoma of prostate	Δ.	
	be executed sician and burial-transit	Ä	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
9	icate be exe physician s the burial-	dical	d			
6876	tificat ng ph as th	Mec	IF FEMALE:			
9 ×	h cer tendii or use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \subseteq Live Birth 2 \subseteq Fetal death 3	Ectopic pregnancy		23d. Date of delivery
Вох	deat the at red fo	/sic	1	Other (specify)		Month Day Year
o	at the d by t letach	P.	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e Did tobaco	to use contribute to the cause of death?
ν. σ.	res th signe	d by		, ,		2 ☐ No 3 ☐ Probably 4 ☒ Unknown
ğ	requi been shoulk	Completed			24a, Was an	24b. Were autopsy findings available
900	e law has ge 2 s	du			autopsy performed	prior to completion of cause of death?
Division of Vital Records,	n: The ficate or, pay		25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 X	No 1 Yes 2 🔀 No
<u>Ita</u>	s cert	To Be	examiner? 1	_ Other: _		6 ☐ Other (Specify)
of	g Phy er this eral c		27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	28d. Describe how in	
on	ath. rr. Aft	lical	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
/ISI	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
	italo ursaf ral Di					
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with 124 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death of (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
	ithin of the omple	Σ	only ene 3 Certifying Nurse Practioner: To the best of my knowledge, a 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		se(s) and manner as stated. Date signed (Month, Day, Year)
	⊢≶⊨ŏ		Nahert H Luay MD			
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, F			5/20/2010
	\			est Glen Road, Sil	ver Spring	a. MD 20910
	Stat	te	31. Date filed (Month, Day, Year) 32. segistrar's Signature	AND AND AND AND AND AND AND AND AND AND	. J. Opt III	
	Registra	ar	MAY 21 2010 Daws S. So	all		